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**UNEARTHING THE 'CLINICAL ENCOUNTER': GARTNAVEL MENTAL
HOSPITAL, 1921-1932. EXPLORING THE INTERSECTION OF
SCIENTIFIC AND SOCIAL DISCOURSES WHICH NEGOTIATED THE
BOUNDARIES OF PSYCHIATRIC DIAGNOSES**

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Abstract

Charting the trans-Atlantic movement of ‘dynamic’ psychiatry from The Henry Phipps Psychiatric Clinic, Baltimore, to Gartnavel Mental Hospital, Glasgow, this thesis throws light upon the resultant ‘dynamic’ case note records, produced in Gartnavel during the 1920s. By undertaking an in-depth, qualitative analysis of Gartnavel’s case note records and corresponding archival materials, I explore the polemical question, posed, amongst others, by Foucault, of how psychiatry achieves its distinct status as a science of the individual. Foucault, most notably in *Discipline and Power*, ascribes to the psychiatric profession the power to fashion individual patient histories into cases, cases which simultaneously emphasise the individuality of a patient, while condensing, i.e. ‘fixing’ their identities that they may be constituted ‘an object for a branch of knowledge and a hold for a branch of power’. This thesis, while recognising the validity of this argument, explores how the clinical practices and philosophical outlook of dynamic psychiatry in the early twentieth century enabled both patient and psychiatrist to negotiate the construction of the psychiatric case note record, and consequently of patients’ individual identities.

D. K. Henderson, physician superintendent of Gartnavel between 1921 and 1932, was one of the first, if not *the* first psychiatrist fully to incorporate dynamic principles into the working practices of a British mental hospital. Initiating methods of case note taking and staff meeting consultation (now integral components of modern day psychiatric practice) he transported the teachings of his mentor, the Swiss émigré psychiatrist Adolf Meyer, to the everyday clinical practices of Gartnavel. The dissemination of dynamic psychiatry through Henderson’s published works and medical teachings is recognised as having integrally shaped the practices of Scottish psychiatry in the twentieth century. However, the significance of the unpublished case note records, produced under his superintendence of Gartnavel during the 1920s, as sources of historical enquiry has gone largely unrecognised. A near-unique archive of ‘dynamic’ case note records is used in this thesis to reveal, what Roy Porter termed, a ‘history from below’ of clinical practices and examinatory processes. For as Henderson employed stenographers and clinical clerks to record verbatim and semi verbatim the dialogues that passed between patients and psychiatrists within staff meetings and mental examinations, I, as Porter himself aspired to, take as the focus of my research a history of the ‘two-way encounters between doctors and patients’.

By employing an interdisciplinary research method, one that incorporates Foucauldian, literary, critical medical humanities, as well as more traditional forms of medical history scholarship, I establish a history of dynamic psychiatry set within clinical encounters. Engaging with current debate, evolving primarily within the interdisciplinary sphere of the medical humanities, I argue these records reveal a history of medical humanism, one in which both patients and psychiatrists actively shaped the history of twentieth century Scottish psychiatry.

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To my family, Andy, Ruth and Kenneth Morrison, and partner Alasdair Thom, thank you for your patience and support.

Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature _____

Printed name _____

List of key terms and abbreviations

Key terms

Biomedicine: A medical model for conceptualising disease that increasingly took root in the psychiatric profession post WWII, becoming the dominant medical model in the 1960s onwards. In accordance with the biomedical model, disease is considered to exist independently of social, psychological and behavioural dimensions of illness. Mental illness is therefore defined as the aberration of ‘somatic (biochemical or neurophysiological) processes’.

Dynamic Psychiatry: ‘Dynamic’ is used to refer to the methods and philosophical outlook of a distinct branch of psychiatry, adopted, amongst others, by D. K. Henderson in the 1920s. Although difficult to reduce to a one sentence definition, dynamic psychiatry interspersed the teachings and methods of many late nineteenth/early twentieth-century schools of psychiatry - such as the psychobiological teachings of Adolf Meyer, the psychoanalytic methods of Sigmund Freud and the symptomatological classifications of Emil Kraepelin – so to deal with the various mental, emotional biochemical and environmental forces that constitute a person’s condition and which steer the course of treatment.

Materialism: The concept of materialism is used to define the dominant psychiatric approach to mental medicine espoused by Western psychiatrists at the turn of the 20th century. In alignment with scholars such as Jonathan Andrews, Carol Berkenkotter and Michael J. Clark, alongside contemporary medical practitioners such as W. H. R. Rivers, I use materialism to denote a thought style that located the aetiology of mental illness to morbid changes in the brain. Mental illness, under such a prevailing thought style, is fore-mostly defined as mental disease, and therefore treated by medicinal means and regimens.¹

Asylum/mental hospital: In the early twentieth century, the old Victorian lunatic asylums were gradually being renamed as mental hospitals. This coincided with the uptake of modern medical practices in mental institutions, replacing regimes of moral management which previously directed the care and treatment of the mentally ill. Gartnavel itself was undergoing such a name change in the 1920s. Formerly

¹ Jonathan Andrews ‘Death and the Dead-House in Victorian Asylums: Necroscopy Versus Mourning at the

known as Glasgow Royal Lunatic Asylum, it was unofficially renamed Glasgow Royal Mental Hospital in the 1920s, having the new name officially recognised in 1931 by charter.

Case note record: Compiled within mental hospitals by clinical clerks and medical officers, the case note record charted the medical history of the patient, followed by daily, weekly, monthly, sometimes yearly progress reports spanning the date of the patient's admission until their death or discharge. The format of the psychiatric case note record alters considerably across the nineteenth, twentieth and twenty-first centuries, with each institution for the care of the mentally ill possessing its own preferred system. In referring to Gartnavel's case note records I refer to records constructed along Meyerian standards of examination and case note taking.

Case history: A patient case note record could be converted for publication into a case history. Published within the annual reports of mental hospitals, or in journal papers and medical text books, these case histories - which normally preserved the anonymity of the patient - were used to communicate to medical and lay audiences the particulars of an individual case and often its diagnostic or prognostic significance.

Abbreviations

AMC: The Adolf Meyer Collection, Alan Mason Chesney Medical Archives, The Johns Hopkins University.

NHSGGCA: National Health Service Greater Glasgow and Clyde Archives.

Chronological table

- 1842** Foundation stone laid for the construction of the new Glasgow Royal Lunatic Asylum at Gartnavel
- 1857** Lunacy (Scotland) Act
- 1892** Adolf Meyer immigrated to America
- 1893** Meyer instigated the use of uniform case note record sheets in Kankakee, Eastern Illinois State Hospital for the Insane, followed by his introduction of the 'staff meeting' amongst the hospital staff.
- 1896-1901** Meyer is offered a job at Worcester Asylum, Massachusetts in 1896. He is granted a sabbatical for the summer of 1896 to study in Kraepelin's Heidelberg clinic. Meyer brings Kraepelin's methods of observation, longitudinal history-taking and standardised record keeping back to Worcester.
- 1901** Landel Rose Oswald appointed physician superintendent of Gartnavel.
- 1902** Meyer was appointed Director of the Pathological Laboratory of the New York State Hospitals.
- 1908** Henderson began his psychiatric training as a clinical assistant in The Royal Edinburgh Asylum, Morningside, under Thomas Clouston and Charles Macfie Campbell who introduced Henderson to case history taking.
- 1908** Henderson, under the recommendation of Campbell, is working within the New York Psychiatric Hospital with Adolf Meyer, where he is introduced to the psychobiological approach, treating mainly syphilitic patients.
- 1909** Meyer is promoted to the Director of the Henry Phipps Psychiatric Clinic, Baltimore and Henderson then comes under the tutelage of August Hoch, who encourages the use of psychoanalytic treatments.
- 1909-10** Laboratory of the Western Asylums' Research Institute established in Gartnavel's grounds. Out-patient Clinic at the Western Infirmary, Glasgow, opened.
- 1911** Henderson studies under Alois Alzheimer, Emil Kraepelin and Ernst Rudin at the Nussbaumstrasse Clinic in Munich. Henderson is critical of Rudin's too dogmatic approach to the diagnosis of dementia praecox, and Kraepelin's lack of empathy towards his patients.
- 1911** Henderson appointed an assistant at Morningside, Edinburgh – under George Robertson. He found the conditions of Scottish psychiatry restrictive and returned to work for Meyer in the Henry Phipps Psychiatric Clinic, Baltimore.
- 1912** In Baltimore, Henderson studied an array of organic and affective disorders, whilst forming a greater appreciation of the psychobiological approach.

- 1913** Mental Deficiency Act passed.
- 1914** The outbreak of WWI and Henderson applies for military and civilian posts within Britain.
- 1915** Appointed as 1st Assistant to Landell Rose Oswald in Glasgow Royal Asylum, Gartnavel, Henderson introduced occupational therapy and Meyer's psychobiological approach to the hospital.
- 1916** Employed as an army psychiatrist, Henderson is first posted to Lord Derby War Hospital, Lancashire, before being transferred to Ypres, France in 1917, then to Netley Military and Dunblane War Hospitals until 1919. Henderson collates the case histories of hundreds of war casualties, in particular dementia praecox patients.
- 1918** Henderson published a report on the 'War Psychoses: An Analysis of 202 Cases of Mental Disorder Occuring in Home Troops'.
- 1919** Henderson returned to Gartnavel as Oswald's assistant.
- 1921** After a year of failing health, Oswald resigns and Henderson is promoted to the position of Physician-Superintendent to Gartnavel. That year he instigates the use of Kraepelinian diagnostic categories, Meyerian case note taking procedures and weekly staff meetings.
- 1922** The Occupational Therapy Pavilion was constructed in the grounds of Gartnavel which saw the appointment of Scotland's first Occupational Therapist, Miss Dorothea Robertson.
- 1923** 'A Review of Service Patients in Mental Hospitals' was jointly published by Henderson and his colleague R. D. Gillespie. The publication endeavoured to inform the lay public, as well as Parliament and the Press of the on-going plight of mental casualties of WWI.
- 1924** A meeting of the Scottish Division of Medico-Psychological Association was held at Gartnavel to discuss and promote the use of Occupational Therapy.
- 1927** Henderson and Gillespie published the first edition of their co-authored *A Text-Book of Psychiatry for Students and Practitioners*.
- 1930** Second edition of Henderson and Gillespie's *Text-Book* published.
- 1932** Third edition of Henderson and Gillespie's *Text-Book* published.
- 1932** Henderson resigns his post at Gartnavel and is appointed Physician-Superintendent of the Royal Edinburgh Mental Hospital and Professor of Psychiatry at Edinburgh University.
- 1936** Fourth edition of Henderson and Gillespie's *Text-Book* published.
- 1940** Fifth edition of Henderson and Gillespie's *Text-Book* published.
- 1947** Sixth edition of Henderson and Gillespie's *Text-Book* published.
- 1950** Seventh edition of Henderson and Gillespie's *Text-Book* published.

- 1956** Eighth edition of Henderson and Gillespie's *Text-Book* published.
- 1962** Ninth edition of Henderson and Gillespie's *Text-Book* published.
- 1965** Henderson publishes *The Evolution of Psychiatry in Scotland*.

AN INTRODUCTION



Figure 1 Illustration from Lewis Carroll's *Through the Looking Glass* (1865). Printed with the permission of *Victorian Web*

... the lives, experiences and understandings of the doctor and the patient can be thought of as two tracks across a world that is not by any means fully mapped out. Where those tracks cross, their different pasts and futures shape the way each understands the other ... Most intriguingly, the clinical encounter is a meeting of two uniquely embodied experiences, each of which has somehow to make sense and respond to the other.¹

One morning in July 1929 a medical officer was conducting his rounds in Gartnavel Mental Hospital, when upon entering one of the female wards he observed Miss Murray, a newly admitted patient, to be acting in what he termed a “high” state. Upon Miss Murray’s admission to the hospital the previous day it had been recorded in her case note file that she spoke to herself ‘a great deal’ and at times ‘got very impulsive’. During the latter part of the morning she had lain in bed: ‘her eyes’, observed a clinical clerk, ‘were flashing and she immediately made strange signs’. As the day went on it was recorded that ‘[s]he blew from her mouth and made movements of her arms which seemed to indicate that she was pushing or brushing away the medical officer ...’

¹ Martyn Evans ‘Roles for Literature in Medical Education’ in *Mindreadings, Literature and Psychiatry* ed. Femi Oyeboade (Glasgow: Royal College of Psychiatrists, 2009) p. 18.

The next day Miss Murray remained in bed and reportedly became ‘very antagonistic’ when a medical officer came to sit next to her. Speaking in a ‘loud declamatory voice’, she warned that if he remained seated in front of her she would spit on him. The medical officer recorded that: ‘I sat. She spat on me, three times; and then she said something like “Thank God, Thank God, he does not flinch”. Her antagonism, noted the medical officer, ‘seemed to go away very largely’; curtains were drawn around the bed and Miss Murray allowed the nursing sister to ‘arrange her dress’ for the physical examination. The medical officer then began to examine her, but ‘again she showed momentary flashes of antagonism’ and proceeded to ‘sing aloud “Danny Boy, Danny Boy”’. This, noted the medical officer, ‘was while I was attempting to auscultate the thorax’. ‘Gradually’, this period of excitement was seen to ‘subside’ and ‘finally’, he wrote ‘I proceeded to talk to the patient ...’:

“Is your head clear?”

“Fairly.”

Do you feel confused?

“No” (definite)

Miss Murray, it was recorded, then ‘made reference to the coming of Heaven’, and proceeded to state ‘... how when she was a child she had a fancy. She looked into a looking glass and saw another room; and that she had wished to get into that other room, the other side of the glass’. Miss Murray was seen to smile when the medical officer mentioned *Alice Through the Looking Glass*, but the medical officer remarked: ‘she seemed to suggest ... we were now “through the glass” – we were through the veil of Death into Heaven’.²

The dynamic approach

‘I was always conscious’, wrote the British-American neurologist Oliver Sacks in 1990, ‘that there were always *two* books, potentially, demanded by every clinical experience’. One would be purely nomothetic, ‘medical’ or ‘classical’ which offered an objective description of ‘disorders, mechanisms and syndromes’, and the other would be idiographic,

² Case note records of the physical and mental examination of a newly admitted female patient. This patient, for reasons of anonymity, is represented by the pseudo name Charlotte Murray. The examination was conducted in Gartnavel Mental Hospital in 1929 and was entered into this patient’s case note records. GB812 HB13/5/187/90 NHS Greater Glasgow and Clyde Archives from now on referred to in this thesis as NHSGGCA.

an ‘existential’, ‘personal empathic entering into patients’ experiences and worlds’.³ Patient case note records, recalled Sacks, which encase lay narratives of illness and experience within the linguistic devices and thought-style of clinical psychiatry, once enjoined both nomothetic and idiographic representations of the clinical encounter through ‘richly, beautifully ... detailed, empathic descriptions’ of the ‘total *picture* of disease’. But, as an era of biomedicine (rooted in the natural sciences such as biochemistry, physics, and physiology) came to dominate Western psychiatric practice in the post-WWII era, the latter half of the twentieth-century marked for many within the cognitive sciences the decline of the clinical narrative which had hitherto enjoined a physiological understanding of mental illness to the more humanistic impulses of psychiatric encounters.⁴

This thesis looks back to an era before the rise of biomedicine, to a period (and a place) in the history of British psychiatry, when a dynamic model of mental illness used both nomothetic and idiographic forms of knowledge within the production of patient case note records.⁵ By carrying out the first in-depth qualitative analysis of case notes produced between 1921 and 1930 at the Glasgow Royal Mental Hospital, often called Gartnavel, I propose that the dynamic approach, which was introduced to the hospital in 1921 under the direction of Physician-Superintendent Dr David Kennedy Henderson, opens up new and exciting vistas for historical-geographical enquiry. For, as academia is no longer content to study in isolation the ‘theories and practices of psychiatrists, or, inversely, the subjective experience of the patient’, I argue such sources allow scholars, circa ninety years on, to explore the interactive dimensions of the doctor-patient relationship from within clinical

³ Oliver Sacks *Awakenings* (1973; repr. London: Picador, 1991) pp. xxxvi-vii.

⁴ A separation of nomothetic and idiographic forms of knowledge production arguably stems from the German hermeneutical tradition, which introduced a ‘sharp distinction between the human and the natural sciences’. Anne Husanker Hawkins writes ‘The nomothetic approach can be described as one that studies events and persons as examples of some general law; its aim is explanatory and its language is that of physiology and anatomy. The ideographic approach, on the other hand, studies events and persons as unique cases; its aim is understanding, and its language is subjective or phenomenological’. See Ruth Leys ‘Types of One: Adolf Meyer’s Life Chart and the Representation of Individuality’ *Representations* 34 (1991) 1-28 pp. 4, 7. See also D. B. Double ‘Adolf Meyer’s Psychobiology and the Challenge for Biomedicine’ *Philosophy, Psychiatry, and Psychology* 14 (2007) 331-339 p. 355. Anne Husanker Hawkins ‘A. R. Luria and the Art of Clinical Biography’ *Literature and Medicine* 5 (1986) 1-15 p. 6. Hazel Morrison ‘Conversing with the Psychiatrist: Patient Narratives within Glasgow’s Royal Asylum 1921-1929’ *Journal of Literature and Science* 6 (2013) 1 18-37 p. 18.

⁵ The Swiss émigré psychiatrist Dr. Adolf Meyer sometimes used ‘psychobiology’ interchangeably with ‘dynamic psychiatry’ and we find in Britain during the 1920s that the term dynamic psychiatry was used to refer to Meyer’s psychobiological psychiatry. See Edwin R. Wallace ‘Historiography’ in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace IV and John Gach (New York: Springer, 2008) p. 3.

encounters.⁶ Feeding into contemporary debate, I use this thesis to challenge reductionist models of studying, explaining and understanding mental illness, by considering the ‘inherent [historically rooted] uncertainty of psychiatry’.⁷

A trans-Atlantic backdrop to the dynamic approach

Henderson, who had trained under some of the most eminent psychiatrists of this period, including Thomas Clouston in Edinburgh, Adolf Meyer in Baltimore, August Hoch in New York and Alois Alzheimer and Emil Kraepelin in Munich, was one of the first and foremost psychiatrists to utilise the dynamic approach within a British mental hospital. Entering the profession at a time in which British psychiatrists were largely critical of the Viennese psychoanalyst Sigmund Freud,⁸ integrating yet not fully grasping the application of Kraepelin’s clinical studies and symptomological classificatory systems,⁹ and unaccustomed to the standardised examinatory techniques and case note taking procedures established by Meyer in North America, Henderson’s approach, which blended Kraepelinian, Freudian and Meyerian teachings, was in many ways pioneering. Upon his ascension to Physician-Superintendent of Gartnavel in 1921, Henderson introduced examinatory and case note taking techniques that were essentially Meyerian, and, as this thesis makes clear, this trans-Atlantic movement of clinical practices and psychiatric knowledges marks a distinct turning point in the development of Scottish psychiatry.

While the leading practitioners of early twentieth-century Scottish psychiatry defined mental illness as a symptom of somatic disorder, rooted in disease and degeneracy, dynamic psychiatrists challenged such reductionist thinking. Before WWI North American pioneers of dynamic psychiatry such as Meyer, William Alanson White and Elmer E. Southard argued for the interaction of biological, social and psychological factors in the aetiology of mental illnesses, and dynamic studies of symptomatology became attentive, not only to the organic aetiology of disease and disorder, but to patients’ thoughts and

⁶ Mikkel Borch-Jacobsen *Making Minds and Madness. From Hysteria to Depression* (Cambridge: Cambridge University Press, 2009) pp. 8-9. See also Roy Porter ‘The Patient’s View, Doing Medical History from Below’ *Theory and Society* 14 Mar (1985) 175-198 p. 175.

⁷ Double ‘Adolf Meyer’s Psychobiology and the Challenge for Biomedicine’ p. 337.

⁸ Rivers *Instinct and the Unconscious* p. 4.

⁹ Within Britain an English translation of Kraepelin’s text book did not become widely available until after the First World War and therefore despite Kraepelin’s seminal differential diagnosis of manic-depressive insanity and dementia praecox having a substantial impact upon Western psychiatry, the substance of his publications were not widely discussed in Britain during this time. See David Healy et al ‘Historical Overview: Kraepelin’s Impact on Psychiatry’ *European Archives of Psychiatry and Clinical Neuroscience* (2008) 258 18-24 p. 20.

feelings in relation to the external world.¹⁰ The focus of this interrelationship was often to be found in the patient's language, and in the wake of the psychoanalytic movement, burgeoning upon the Continent and in North America, personality studies, dream analysis, word association tests and talking therapies became part of the dynamic psychiatrist's investigatory and therapeutic arsenal.¹¹ By the turn of the century, new examination and recording technologies were gradually introduced to North American mental hospitals, and with these new technologies came the production of verbatim and semi-verbatim accounts of the dialogues that passed between patients and psychiatrists within clinical encounters.¹² Henderson was one of the first, possibly *the* first psychiatrist fully to incorporate such dynamic principles and recording techniques into the working practices of a British mental hospital, and it is from these dynamic case note records that a history of the 'two-way encounters between doctors and patients' may be unearthed.¹³

To understand the ideological backdrop to 'dynamic' case note record construction, it is first to a brief history of Meyer that this introduction turns, to be followed by an overview of the dynamic case note records constructed in Gartnavel. This introduction then sets out why, and more specifically how, this thesis offers a unique contribution to histories of psychiatry/mental illness.

Adolf Meyer

Meyer, one of the most influential psychiatrists during the first half of the twentieth century, directed North American psychiatry away from Kraepelin's preoccupation with symptomatology and classification, and towards studies of the 'personality', which united psychological studies of experience and individual subjectivity with pathological anatomy.¹⁴ Inspired by the evolutionary principles of Herbert Spencer, Meyer taught that, just as the central nervous system was engaged in the biological struggle of adaptation, so

¹⁰ Nancy Tomes 'Development of the Mental Health Professions' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 658.

¹¹ Sander L. Gilman 'Constructing Schizophrenia as a Category of Mental Illness' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 467.

¹² The vast uptake of Meyerian methods of case note taking may be seen in contemporary literature. For example, see Elbert M. Somers 'The Value of Staff Conferences in State Hospitals' *American Journal of Psychiatry* 66 (1910) 571-77. See also Charles F. Read 'Clinical Staff Conference' *American Journal of Psychiatry* 93 (1937) 1391-1400.

¹³ Roy Porter 'The Patient's View, Doing Medical History from Below' *Theory and Society* 14, Mar (1985) 175-198 p. 175.

¹⁴ Leys 'Types of One' pp. 2-4.

too was the mind, and that it was through an individual's physical and mental adaptations to their environment that the 'totality of the person', i.e. their underlying personality, took shape.¹⁵ Mental illness, within such a conceptual sphere, was regarded as the 'cumulative result of unhealthy reactions of the individual mind to its environment', and therefore Meyer replaced the concept of mental illness as disease with mental illness as a reaction type 'that required both physical and psychological explanation'.¹⁶

In order to unearth the seat of such unhealthy reactions, a 'narrative or biographical component' was essential to Meyer's psychiatric approach.¹⁷ All the potentially relevant factors in a case were to be 'made objectively evident' through longitudinal studies of an individual's 'life history'; accompanied by observations of the patient's reactive tendencies within clinical environments. Interviews with patients' friends and relatives were initially used to compile a hereditary and personal history, but most crucially the patient's own subjective 'story' of illness and experience was to be elicited through conversation with the psychiatrist. Moreover, while the aetiology of mental illness was to be found in the life history, therapeutic intervention was likewise reliant upon psychiatrists' understanding of patients' physical and experiential history. 'The psychiatrist', wrote Meyer '- the user of biography - must help the *person himself* ... to restore ... the capacity for self-regulation'.¹⁸ This demanded they develop a 'sensitivity to the "stories" ... the patient may just chance tell' so as to guide the patient down the best possible path of 'adjustment and adaptation'.¹⁹ Unlike Freud, Meyer deferred from transforming patient stories into complex, theory-laden narratives. Rather he used the patient's '*own language*' and the patient's own understanding of their illness as the basis for any 'advice and further elucidation'.²⁰ An empathic, non-reductionist approach was promoted, one which used the inter-subjective relationship between patient and psychiatrist as both an 'investigational and therapeutic tool', and through the use of talking and occupational therapies, Meyer

¹⁵ Susan Lamb 'Pathologist of the Mind: Adolf Meyer, Psychobiology and the Phipps Psychiatric Clinic at The Johns Hopkins Hospital, 1908-1917.' Unpublished Dissertation Thesis, Baltimore: The Johns Hopkins University, 2010 pp. 3, 30.

¹⁶ Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 390.

¹⁷ Leys 'Types of One' p. 5.

¹⁸ Many contemporary writers use masculine terms such as 'him' 'his' or 'himself' to speak of both men and women. This masculine gendering of language is retained in the primary sources throughout the thesis, but I apply a loosely feminist perspective in this thesis which critiques such discursive gendering.

¹⁹ Adolf Meyer 'Therapy' in *Psychobiology, a Science of Man* eds. Eunice Winters and Anna Mae Bowers (Illinois: Charles C Thomas, 1957) pp. 157-160.

²⁰ Meyer 'Therapy' p. 164.

endeavoured to guide patients down the ‘best possible’ path of ‘adjustment and adaptation’.²¹

To transform such individual life histories into clinically ‘objective’ facts, Meyer’s long-lasting contribution to North American psychiatry was to standardise methods of examination and case taking procedures.²² ‘The art of history-taking’ observed Henderson when reflecting upon Meyer’s teachings, was ‘invaluable in relation to prognosis, diagnosis and treatment’.²³ Rather than accumulate long and unbridled biographies, Meyer set out to convert ‘ephemeral experience’ (that of the patient and psychiatrist) into data that could be accumulated, compared and collectively evaluated, thereby enabling psychiatry to operate as a clinical science.²⁴ Spelling out to his students and fellow colleagues the order of the examination procedure, the ‘essential data to be ascertained’ and the important questions to be put forward, psychobiological methods of case note taking became the cornerstone of North American psychiatric practice in the decades to come.²⁵

The dynamic case note record

Upon Henderson’s ascension to Physician-Superintendent in Gartnavel, the inspirational teachings of Meyer motivated him to push Scottish psychiatry away from its former emphasis on the description of symptoms, classification and brain pathology, and towards the study of the individual personality, set within and reacting to his or her environment. From pivotal moments in a patient’s confinement, such as the physical and mental examination, the actions, emotions and volitions of patients such as Miss Murray (whose case introduces this thesis) were bound to the narrative structures and routine techniques of Meyerian case note taking practices. As Gartnavel’s medical officers could use common cultural discourses, metaphor and metonym to engage with the phenomenological worlds of their patients (as evidenced by the reference made to Lewis Carroll’s *Through the*

²¹ Lamb ‘Pathologist of the Mind’ pp. 12, 16. See also Meyer ‘Therapy’ pp. 157-58.

²² The case note record was not only to be treated as ‘a mean of self-defence in case of accidents and complaints’; it was not a mere ‘record of treatment without a statement of indications’ nor one of ‘diagnosis without a statement of what it implies and is based upon’, rather it was to consist ‘in getting all information available on a patient concerning the past, and all information that a repeated complete and careful examination will furnish’. See Adolf Meyer ‘A Few Remarks Concerning the Organization of the Medical Work in Large Hospitals for the Insane’ first privately printed on Wards Island New York in 1902, reprinted in *The Collected Papers of Adolf Meyer Vol II Psychiatry* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) pp. 83-84.

²³ D. K. Henderson ‘Introduction’ in *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) p. xii.

²⁴ Lamb ‘Pathologist of the Mind’ p. 17.

²⁵ GB812 HB13/5/187/90 NHSGCA. See also Lamb ‘Pathologist of the Mind’ p. 1-4.

Looking Glass), these dialogues became the conduit through which Gartnavel's practitioners explored how the inner workings of a patient's mind adapted to its environment.²⁶

In Miss Murray's case note records, we therefore see that, while the clinical encounter was recorded from the perspective of the psychiatrist, the narrative of the patient, and indeed her non-verbal forms of communication, such as a glance or spit, were accorded a high degree of significance. The organic origins of disease was regarded as being of great etiological importance (as evidenced by the psychiatrist's attempt to 'auscultate the thorax'),²⁷ yet Henderson taught that it was equally as vital to let the patient tell their own story so that they were understood as a 'human being' reacting to distinct physical states and environmental conditions rather than a mere organic entity.²⁸ A 'personal empathic entering into patient's experiences and worlds'²⁹ was precisely that which was demanded by Henderson; and, as Gartnavel's medical officers endeavoured to unearth the faulty reactions of 'thought and feeling' that bound patients to their physical and social environments, the life history and prior experiences of the patient were considered a most valuable component of the case note records.³⁰

Moreover, while Henderson initiated 'the most up-to-date practices in clinical case-note taking', staff meetings, now known as the forerunner to the contemporary 'case conference', were put into use in Gartnavel from 1921 onwards.³¹ In emulation of staff meetings conducted by Meyer within the United States, Henderson instigated the routine by which 'three mornings weekly' Gartnavel's staff gathered within a meeting room and were introduced to newly admitted patients, whose cases they then went on to discuss. Used as an educational and training exercise, staff meetings consisted of a single examining psychiatrist directing questions towards the patient, while a stenographer, who

²⁶ Lamb 'Pathologist of the Mind' pp. viii, 68-81.

²⁷ To 'auscultate' is to listen to the breath sounds using a stethoscope. The thorax is the part of the body between the neck and the diaphragm.

²⁸ D. K. Henderson and R. D. Gillespie *A Text-Book of Psychiatry for Patients and Practitioners* (Edinburgh: Humphrey Milford, Oxford University Press, 1927) p. i.

²⁹ Sacks *Awakenings* pp. xxxvi-vii.

³⁰ Henderson and Gillespie 'Preface' in *A Text-Book of Psychiatry* (1927) pp. i, 75.

³¹ Iain Smith and Alan Swann 'Medical Officers and Therapeutics, 1921-1993' in *A History of Gartnavel Royal Hospital from its Beginnings to the Present Day* eds. Jonathan Andrews and Iain Smith (Glasgow: Gartnavel Royal Hospital, 1993) p. 329.

sat silently among the staff, recorded word by word the conversation that passed between patient and practitioner.³²

In accordance with psychobiological principles, which envisaged mental illness as the unhealthy reaction of an individual to their environment, the staff meeting was itself considered an ‘experimental stage’ upon which patients’ reactive tendencies were to be judged and given meaning. So, while the acts and utterances of the patient were recorded, so too were the provoking actions of the psychiatrist. Verbatim transcripts of staff meetings were often recorded in a simple question and answer format, so that the precise interactions between patient and practitioner were presented in their original stream of the event.³³ It is from these records that we hear most clearly the interactive dimensions of the patient-psychiatrist relationship within the distinct settings of clinical encounters. Recorded from the perspective of the stenographer who sat clicking away at their stenographic machine, such sources, preserving the raw and largely unmediated dialogues that passed between patient and practitioners within staff meetings, allow a deep hermeneutic enquiry into the illness narrative as it was shared, modified and negotiated by both medical officer and patient. And, while we are subtly made aware of those other members of staff, sitting within the meeting room, we may begin to populate, within the mind’s eye, those institutional environments, so often hidden from historical-geographical enquiry, in which clinical encounters were performed.

Moreover, once the patient had been escorted out of the meeting room, debate and discussion of the case continued between Gartnavel’s staff. In emulation of Meyer, these staff meetings were places where both junior and senior medical officers were expected to give explicit reasoning for diagnostic decisions and plans for therapeutic treatment. Through the regular use of simple, commonly used words, which were largely unadulterated by complex terminologies, Henderson, in emulation of Meyer, advocated that psychiatrists capture as closely as possible the objective, common-sense facts of the case in a uniform and systematic fashion.³⁴ There was no use, argued Meyer, in providing a

³² Henderson’s employment of a stenographer within the staff meetings emulated the methods of Adolf Meyer who, in the mid 1890s, initiated the first staff meeting in Illinois Eastern Hospital for the Insane, Kankakee. See Andrew Scull ‘Psychobiology, Psychiatry, and Psychoanalysis: The Intersecting Careers of Adolf Meyer, Phyllis Greenacre, and Curt Richter’ *Medical History* 53 (2009) 5-36.

³³ George Hughes Kirby *Guides for History Taking and Clinical Examination of Psychiatric Cases* (Utica: New York State Hospitals Press, 1921) pp. 5-7, 57. See also Sir David Kennedy Henderson *The Evolution of Psychiatry in Scotland* (Edinburgh: E. & S. Livingstone Ltd, 1964) p. 160.

³⁴ Leys ‘Types of One’ p. 5.

diagnosis without backing it up with a description of ‘what it implies and is based upon’, and neither was a record of treatment considered adequate unless the actual process and the results obtained were given due consideration.³⁵ The staff meeting was to lay bare the psychiatrists’ decision-making process and the actual implications of treatments, and these practices are clearly set out within Gartnavel’s staff meeting transcripts.

Furthermore, ‘under the critical eye of all the physicians of the hospital’, debates and disagreements flowed between staff members, and transcripts reveal that these meetings acted as a clearing-house for the individual, sometimes, oppositional views of Gartnavel’s medical officers. Henderson, who presided over these meetings, often took the opportunity to instruct and advise, as well as be informed by his colleagues, and these gatherings functioned as both a teaching and a consultation space. A consensual agreement as to the prognosis, diagnosis and plans for treatment was the intended outcome of these meetings,³⁶ and, as the stenographer continued to type away at their stenographic machine, these records evidence how ‘knowledge [was] applied and practice organi[s]ed in [psychiatric] medicine’.³⁷

Throughout a patient’s stay in the mental hospital the collation of family reports, medical certificates, staff meetings transcripts, patient writings and records of the daily, weekly, monthly, sometimes yearly repeated mental and physical examinations all functioned to give a ‘live continued account’ of patients’ mental reactions in their transition from society to the ‘strange experimental field’ of the mental hospital.³⁸ The preservation of patient narratives and the ‘table talk’ of psychiatric practitioners therefore allow for a critical examination of the clinical encounter before its proceedings were condensed and revised within official, published reports.

Contextualised within cultural, institutional and material settings, these records, moreover, allow for an analysis of the narrative construction of patient identities and diagnostic categories from within institutional confines.³⁹ At a micro-historical level, records of particularly decisive interactions between doctors and patients allow this thesis to explore

³⁵ Meyer *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* p. 84.

³⁶ Read ‘Clinical Staff Conference’ p. 1391.

³⁷ Borch-Jacobsen *Making Minds and Madness* pp. 8-9.

³⁸ Adolf Meyer ‘Outlines of Examination’ *The Collected Papers of Adolf Meyer Vol III Medical Teaching* (Baltimore: The Johns Hopkins Press, 1951) p. 237.

³⁹ M. R. Sommers ‘The Narrative Construction of Identity: a Relational and Network Approach’ *Theory and Society* (1994) 605-649 p. 607.

the emergence of new psychiatric theories or symptomatologies.⁴⁰ Furthermore, it may be argued that staff meeting transcripts and case note records enable their readership to imagine, feel and hear life differently from patients' and psychiatrists' situated perspectives.⁴¹ In alignment with Mikkel Borch-Jacobsen's call for micro-level medical histories, these sources allow an approach which, 'unlike traditional psychiatric history[,] ... studies not ready-made theories and syndromes, but those theories and syndromes *in the making*'.⁴²

When trying to assess how these discrete events may have shaped wider histories of Western psychiatry - for instance, of the evolution of diagnostic categories or of public perceptions of mental illness - the study of case note records does of course have its limitations. Generalisations about the development of psychiatric thought, for example, cannot easily be drawn, but the case note record's published counterpart, the single subject case history, provides a further avenue of enquiry. Within 1927 Henderson and his colleague R. D. Gillespie co-authored a *Text-Book of Psychiatry for Students and Practitioners* that used case histories to demonstrate tangibly the interaction of organic and environmental factors in the causation of mental disorders. The *Text-Book*, having gone into nine editions during Henderson's life time, was a standard text for British medical students well into the 20th century and therefore, as I argue in the penultimate chapter of this thesis, it was through the publication of multiple case histories that Henderson was able to challenge publicly the authenticity of contemporary diagnostic categories, and to devise and disseminate new diagnostic constructs such as the 'psychopathic states', over the decades to come.⁴³ Moreover, with the aetiology of mental illness seen to stem from both environmental and organic origins, dynamic psychiatrists such as Henderson and Meyer played a leading role in the inauguration of social welfare provision, while fighting to de-stigmatise public perceptions of mental illness sufferers.⁴⁴ Stressing the significance of early intervention through *Text-Book* and journal publications, Henderson, in

⁴⁰ Borch-Jacobsen *Making Minds and Madness* p. 9.

⁴¹ Arthur W. Frank 'The Standpoint of the Storyteller' *Qualitative Health Research* 10 (2000) 3, 354-365.

⁴² Borch-Jacobsen *Making Minds and Madness* p. 9.

⁴³ Peter Tyrer 'Personality Disorder' *British Journal of Psychiatry* (2001) 179, 81-84, p. 81 describes the influence Henderson had over himself and his contemporaries studying psychiatry in the 1960s.

⁴⁴ Meyer played a leading role in the inauguration of the National Committee on Mental Hygiene movement, which was founded by an ex-psychiatric patient, Clifford Beers. As Nancy Tomes writes of dynamic psychiatrists such as Meyer and W. A. White: 'at the turn of the century ... the extent of urban poverty and crime, as well as the failure of traditional institutions to eliminate them, deepened reformers' appreciation of the environmental causes of individual misfortune and misbehavior ... that increased the likelihood of producing 'mentally "maladjusted" individuals'. Tomes 'Development of the Mental Health Professions' pp. 658-59.

partnership with social workers, general practitioners, theologians and educationalists, slowly widened the provision of mental health care to outpatient clinics and mental welfare organisations.⁴⁵

‘One thing’, Henderson and Gillespie wrote in the preface to the first edition of the *Text-Book*, will become most ‘apparent to the reader; namely, how much regarding the nature of mental illness remains unknown’.⁴⁶ Diagnostic uncertainty was readily acknowledged, which pushed Henderson to problematise classificatory systems that ‘attempt ... to fit all cases into the [diagnostic] rack thus constructed’.⁴⁷ Henderson’s reliance upon detailed, single subject case histories was tantamount to his dynamic approach, yet was in no way seen by Henderson to undermine the legitimacy of dynamic psychiatry. By regarding mental illness as the ‘unhealthy *reactions* of an individual mind’ to its entire physical and social ‘environment’, Henderson embraced diagnostic uncertainty throughout his career. At bedrock, dynamic psychiatrists held on to the hypothesis that:

Mental illness is an individual affair. Its symptoms have little meaning apart from the setting in which they occur. This setting includes not only the general mental and physical condition at the time, but the individual’s personality, circumstances and history from his earliest days. Hence general descriptions of clinical syndromes, while interesting, are not of first importance. What is wanted always is an understanding of the patient as a human being, and of the problems which he is meeting in a morbid way with his “symptoms”. It is in accordance with these principles, and with what is called the “dynamic” view, that we have utilised clinical records so extensively.⁴⁸

Taking these constituent components of dynamic psychiatry into account, it becomes evident that the dynamic case note record performed what some may term a ‘cosmologi[s]ing’ function: enjoining the outer socio-historical context of the clinical encounter to the inner world of psychic disruption and neurological disorder.⁴⁹ The narrative structure of Gartnavel’s case note records and case histories mesh the external spatialities of the clinical encounter with the more intimate, felt worlds of patients and

⁴⁵ This will be expanded upon in chapter 4.

⁴⁶ During the 1960s and 70s the rise of the biomedical model alongside the publication of the Diagnostic and Statistical Manual of Mental Disorders III, III-R made the publication of the single subject case history increasingly obsolescent, and text-books such as Henderson and Gillespie’s, which continued to be published well into the 1960s, likewise went out of print. See Berkenkotter *Patient Tales* pp. 2-3.

⁴⁷ D. K. Henderson and R. D. Gillespie *A Text-Book of Psychiatry* (London: Humphrey Milford, Oxford University Press, 1932) p. 12.

⁴⁸ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. viii.

⁴⁹ Hawkins ‘A. R. Luria and the Art of Clinical Biography’ p. 8.

practitioners, and such records therefore demonstrate how ‘both worlds’ - ‘the outer world of culture and history’ and the inner world of ‘biochemical processes’ and phenomenological experiences - were explored to ‘define and delimit the individual through their respective norms and laws’.⁵⁰ Through the analysis of these two distinct, yet intertwining, worlds - inhabited by patients and practitioners - this thesis ultimately questions how the ideological framework of dynamic psychiatry allowed for new knowledges to emerge from the doctor-patient relationship.

Historiographical backdrop of the case note record

The rarity of such sources cannot be understated, for, as medical historians John D. Stoeckle and J. Andrew Billings claim, to learn about the exchange that took place between doctors and patients in clinical encounters before the 1940s is difficult. ‘[B]efore the first recordings of actual interviews (audiotapes of psychiatrists and patients in the 1940s) the complaints of medical patients and the questions of their doctors were hard to reconstruct from the memories of either’.⁵¹ Within the United States examples of contemporary staff meeting transcripts are few and far between, with a small number dating to the late-1920s and 1930s existing within medical archives relating to the work of psychiatrists Adolf Meyer and his pupil Harry Stack Sullivan.⁵² In Britain, staff meeting transcripts produced in Gartnavel from 1921 onwards are the only known records of their kind to emerge from British medical archives dating back to such an early period. Likewise, Gartnavel’s case note records are themselves a rare example of Meyer’s dynamic approach being appropriated in a British mental hospital in the immediate post WWI years.

Yet, while the dynamic approach facilitated a deep hermeneutic encounter between patient and practitioner, the records of which are now ripe for scholarly enquiry, it would be naive to envisage the corresponding case note records as transparent representations of clinical encounters played out within institutional settings. For, while case note records convert the complex, often fractured and incomplete signs and symptoms of illness into a structured, linear, portrayal of a patient’s life history, a critical appraisal of these sources by scholars such as Michel Foucault, George Rousseau and Brain Hurwitz has led academia to

⁵⁰ Ibid.

⁵¹ John D. Stoeckle and J. Andrew Billings ‘A History of History-Taking: The Medical Interview’ *Journal of General International Medicine* 2 Mar/Apr (1987) 119-127 p. 119.

⁵² Clarence G. Schultz ‘Sullivan’s Clinical Contribution During the Sheppard Pratt Era – 1923-1930’ *Psychiatry* 41 May (1978). Also Box I ‘Staff Conferences, 1929-1936’ in the Adolf Meyer Collection, The Alan Mason Chesney Medical Archives, The Johns Hopkins University, cited in this thesis as AMC.

question how the ‘performative aspects’ of such encounters, such as ‘the telling, questioning, listening, and sharing’ of experience, are transformed by medical practitioners into textually constructed pictures of illness.⁵³

Still commanding considerable attention is the approach taken by Foucault to the analysis of case note records. Within *Discipline and Punish*, psychiatric methods of examination and case note record production were viewed as ‘mechanisms of discipline’, constituting ‘a new type of power over bodies’ which objectified and negated patient agency.⁵⁴ The unequal dispersion of power and authority within clinical encounters has been given considerable attention by several generations of scholars, and in some quarters case note records have been recognised as ‘a means of control and domination’ which masked, suppressed and obscured the histories of asylum patients and practitioners.⁵⁵ ‘If we rarely hear the ‘voice of the mad’, Porter asserted, then we hear ‘even less of the table-talk ... of madhouse-keepers’ as their minds were ‘effectively masked ... behind prospectuses, parliamentary answers and clinical case-notes’.⁵⁶

Most notably, scholars whose primary interests lie with unearthing patient testimony and the experiences of asylum patients have rejected patient case note records for historical enquiry. For scholars such as Kerry Davies, it is argued that patient case notes ‘privilege the voices of psychiatrists’ over the voices of patients. Patients’ speech, Davies observes, was often recorded ‘as signs of illness or cure rather than communication in [its] own right’ and therefore patient case note records are judged to offer a partial and medically orientated record of patient testimony.⁵⁷ Despite such criticisms of the case note record as a source for historical enquiry, scholars such as Donald P. Spence write that to access the point at which patients’ subjective experiences of illness and identity were transformed into comparable, knowable diagnostic entities, the study of ‘clinical material’ rather than published reports, is crucial, for: ‘Once the record has been changed and the case report is published, it is almost impossible to reconstruct what really happened and to isolate actual

⁵³ Brian Hurwitz ‘Form and Representation in Clinical Case Reports’ *Literature and Medicine* 25 (Fall 2006) 216-240 pp. 217, 235-236. See also Arthur Kleinman *The Illness Narratives, Suffering, Healing and the Human Condition* (USE: Basic Books, 1988). George Rousseau *Enlightenment Borders, Pre- and Post-Modern Discourses: Medical, Scientific* (Manchester: Manchester University Press, 1991).

⁵⁴ Michel Foucault *Discipline and Punish, the Birth of the Prison* (New York: Vintage Books, 1995) pp. 185-191.

⁵⁵ Warwick Anderson ‘The Case of the Archive’ *Critical Inquiry* 39, 3 (Spring 2013) 532-547 p. 536.

⁵⁶ Roy Porter *Mind Forg’d Manacles, a History of Madness in England from the Restoration to the Regency* (Cambridge: Harvard University Press, 1987) p. 275.

⁵⁷ Kerry Davies ‘“Silent and Censured Travellers”?’ Patients’ Narratives and Patients’ Voices: Perspectives on the History of Mental Illness since 1948’ *Social History of Medicine* 14 (2001) 267-292 p. 267.

cause and effect'.⁵⁸ Case records, writes Andrew Scull, 'for all their limitations ... allow us to explore the actual use and implementation of [psychiatric treatments] in clinical settings, rather than relying upon the claims and assertions made in the published professional literature'.⁵⁹

Historiography of psychiatry/mental illness

With such diversity of opinion surrounding the use of case note records, the wider historiography of psychiatry/mental illness reflects such disciplinary tensions. Until most recently this wider historiography has largely been polarised, made divisible by cultural, economic, sociological, architectural and scientific studies.⁶⁰ 'Relations between the historically trained and the clinically qualified', remarks Scull, 'have often been tense, if not openly hostile',⁶¹ while a 'lacuna within the historiography of psychiatry', argues Gayle Davis, marks an absence of studies taking seriously the subject of the 'clinical' encounter.⁶² But with dynamic case note records proving such a rich archival remnant of clinical encounters, this study endeavours to bridge the gap between social and clinical histories of psychiatry/mental illness. Not 'content with describing the theories and practices of the psychiatrist, or, inversely, the subjective experience of the patient', the dynamic case note records of Gartnavel permit this thesis to explore:

⁵⁸ Akihito Suzuki 'Framing Psychiatric Subjectivity, Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century' in *Insanity, Institutions and Society 1800-1914: A Social History of Madness in Comparative Perspective* eds. Joseph Melling and Bill Forsythe (London: Routledge, 1999) p. 116. See also Scull *The Insanity of Place/The Place of Insanity* p. 137. Donald P. Spence 'Narrative Smoothing and Clinical Wisdom' in *Narrative Psychology, the Storied Nature of Human Conduct* ed. Theodore R. Sarbin (New York: Praeger Publications, 1986) p. 215.

⁵⁹ Scull *The Insanity of Place/The Place of Insanity* p. 137. See also Arthur W. Frank *The Wounded Storyteller, Body, Illness, Ethic* (Chicago: University of Chicago Press, 1995). Moreover, Gayle Davis contends that case note records remain 'a rich but neglected source amongst historians of medicine'. The 'confidential nature of patient records, the sheer volume of some collections, and the technical complexity of some of the information they contain' argues Davis, 'have acted as disincentives to their use for historical research'. Gayle Davis *The Cruel Madness of Love Sex, Syphilis and Psychiatry in Scotland, 1880-1930* (Amsterdam – New York: Rodopi, 2008) p. 23. Andrews likewise remarks that scholarly negligence of case note records may stem from the 'inconvenient' nature of materials that are hand written, that pose problems of access and which do not easily lend themselves to quantitative analysis. Jonathan Andrews, 'Case notes, Case histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century' *Social History of Medicine* (1998) 11 2 255-281 p. 256.

⁶⁰ For discussions on the polarities which divide histories of psychiatry/mental illness see Davis *The Cruel Madness of Love* p. 17 see also Scull *The Insanity of Place/The Place of Insanity* p. 132.

⁶¹ Scull *The Insanity of Place/The Place of Insanity* p. 132.

⁶² Davis *The Cruel Madness of Love* p. 17.

... how both these objective theories and this subjective experience emerge from beliefs, preconceptions, and expectations that are shared, negotiated, and modified by both the theorist and his patient ...⁶³

‘Not only medical science’, states Martyn Evans, ‘but also ... literature and history and philosophy and anthropology and psychology (among others) are at stake in understanding and describing that encounter’.⁶⁴ Taking inspiration from work currently evolving within the interdisciplinary sphere of the critical medical humanities, alongside that which continues to emerge from the spatially orientated approach of human historical geographers, my own methodological approach blends an in-depth hermeneutic encounter of the recorded dialogues that passed between patient and practitioner during the clinical encounter with a wider analysis of the spatial-cultural-historical contexts in which such dialogues were set. Stimulated by the work of Sacks and those proceeding him, who employ a narrative, biographical approach to the understanding of clinical encounters, this thesis uses the art of storytelling to refocus attention from current biomedical preoccupations with ‘biological and genetic aspects of [mental] health’,⁶⁵ to the ‘complex, highly mediated process’⁶⁶ by which psychiatric diagnoses have historically taken shape.

It is hoped that, by exposing the complex interplay between nomothetic and ideographic forms of knowledge production, as encased within the dynamic case note records of Gartnavel within the 1920s, histories of the personal, the professional and the wider cultural and medical backdrops to these sources will begin to emerge, not as distinct but as mutually dependent and interrelated subjects of historical enquiry. Set within a coherent, if complex trajectory of personal, professional and social histories, this thesis questions how Henderson’s appropriation of dynamic psychiatry allows us, some 90 years on, to explore the emergence of new psychiatric knowledges from these historical doctor-patient relationships.⁶⁷

⁶³ Borch-Jacobsen *Making Minds and Madness* pp. 8-9.

⁶⁴ Evans ‘Roles for Literature in Medical Education’ p. 18.

⁶⁵ David Pilgrim ‘The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future?’ *Journal of Mental Health* 11 (2002) 6 585-594 p. 591.

⁶⁶ Felicity Callard ‘Psychiatric Diagnosis: the Indispensability of Ambivalence’ *Journal of Medical Ethics* 10 Feb (2014) 1-5 p. 1.

⁶⁷ Borch-Jacobsen *Making Minds and Madness* pp. 8-9.

Issues surrounding the reproduction of case note materials

In regards to the ethical and legal prerequisites to the presentation of patient case note records, I recognise the potentially distressing and/or harmful nature of disclosing personal information regarding patient records. Therefore in alignment with NHS procedures (which included an application to the NHS Privacy Board) and the Data Protection Act of 1998, photographs of the original source materials are reproduced, but information that may reveal the identity of the patient is obscured from view.⁶⁸ This method, which retains the anonymity of patients and their families, has resulted in the use of pseudonyms. Specific case note materials are identified by the patient number and the case-book or case file reference. Precise dates of admission are also obscured; but, because this study looks to the cultural specificities which shaped the clinical encounter, the year and the month of admission is often referred to, so to allow the analysis of the distinct social parameters that shaped each individual case. This thesis arguably treads a fine, often contentious line, between respecting the privacy of patients and their families and articulating their unique, historically valuable life histories. Words, writes Cheryl McGeachan that emerge from therapeutic encounters ‘need to be heard and treated respectfully’. Only then ‘might they be allowed to do ‘disruptive’ work snapping at the heels of opinion and discourse’.⁶⁹ Further discussion on sampling, reproduction and analysis of case note records is discussed in chapter 3.

Synopsis of thesis

To explore more fully the historiographical backdrop against which this thesis is set, chapter one, entitled ‘The Walls of Madness were Broached’, traces academic engagements with psychiatric case note and case history records from the early 1950s through to the present day. This introduction will evaluate the major paradigmatic trends that have shaped the evaluation of patient records, most particularly the division of nomothetic and idiographic studies, while laying down how my own methodological approach has been shaped by such works.

⁶⁸ After applying to Dr Linda de Caestecker, Director of Public Health for the NHS Greater Glasgow and Clyde in 2010, I was granted permission to access and to use - for the purpose of academic research - the case note records of Glasgow’s Gartnavel Mental Hospital patients up until an admission date of 1930. This access period was later extended to records that dated up to 1931.

⁶⁹ Chris Philo and Cheryl McGeachan ‘Words’ in *The Sage Handbook of Human Geography* SAGE (In Press) eds. Roger Lee, Noel Castree, Rob Kitchin et al, p. 18 of chapter as an unpublished single article.

Chapter two, entitled ‘Henderson, Meyer and the Trans-Atlantic Movement of a Dynamic Approach’, looks back to the early career of Henderson from 1908 to his appointment as Physician-Superintendent to Gartnavel in 1921. The structure of this chapter endeavours to integrate an intellectual history of ideas with a social, bordering on biographical history of the experiences that led Henderson to introduce the practice of dynamic psychiatry to Gartnavel in the 1920s. By exploring the wider historical, philosophical, methodological and personal histories behind Henderson’s dynamic psychiatric principles, this chapter gives a greater depth of understanding to the subsequent construction of case note, and staff meeting, records within Gartnavel. Through the analysis of correspondence materials written between Adolf Meyer, Henderson and a number of their mutual colleagues, sourced from the Adolf Meyer Collection, The Allan Mason Chesney Medical Archives, Baltimore, which date between 1908 to the early 1920s, alongside a close reading of Henderson’s autobiographical text entitled *The Evolution of Psychiatry in Scotland* (1964), this chapter brings the thesis chronologically up to the major historical period and geographical location which is the locus of investigation.

Chapter three, entitled ‘Anatomy of the Archives, a Methodological Approach’, presents an overview of the case note materials used within this thesis. This chapter begins by giving an account of Henderson’s transition from army medical officer to Physician-Superintendent in Gartnavel in 1921, before turning to a critical appraisal of my own methodological approach to the dynamic case note records produced under Henderson’s direction. A sampling of 63 patient case note records were taken from a total of 1391 patients admitted to Gartnavel between 1921 and 1930, and this chapter makes clear how these sources have been examined, understood and reproduced throughout this thesis. Paying particular attention to the multiple authors of these sources, - consisting of medical officers, clinical clerks, nurses and stenographers - I highlight the inconsistencies and the divergent points of view embedded within such records.

To explore how dynamic psychiatry became infused within Gartnavel’s clinical environment between 1921 and 1931, the following three chapters utilise patient case note records to throw light upon this transformative process. Firstly in chapter four, entitled ‘Dynamic Patient Case Note Records, Under Construction’, I carry out a qualitative analysis of case note records produced under Henderson’s Physician-Superintendence between 1921 and 1931, sourced from NHS Greater Glasgow and Clyde Archives, The Mitchell Library, Glasgow. Analysis commences with three distinct imperatives in mind.

On the one hand it aims to demonstrate that which marks Gartnavel's case note records as being particularly Meyerian in their form and structure. Yet, in addition to this simple correlation, these case note records also evidence how Henderson tailored Meyer's teachings to his own specifications. The imperative of this chapter is therefore to question how Henderson enjoined Meyerian, Kraepelinian and psychoanalytic knowledges to his own evolving sense of psychiatry, thereby transforming Meyer's examination and case note taking procedures. Thirdly, chapter four explores the interactive dimensions that existed between patients, psychiatrist and family members. While laying out, step-by-step, the examination techniques and case taking procedures used to construct case note records, I highlight the underlying fluidity of these documents, which relied so heavily upon the subjective narratives of patients and family members alongside the observations of individual staff members. By picking out distinct moments in an individual's transition from a member of society to a patient undergoing hospital care - such as the process of admission, the physical and then the mental examination - I reflect upon the construction of patients' medical identities within distinct spatial and temporal environments.

Chapter five, entitled 'Diagnosis and Prognosis through the Lens of the Staff Meeting', is again made divisible, structured under three major subheadings. Firstly, verbatim transcriptions of staff meetings are used to transport us back into those hospital spaces where the processes involved in prognosis, diagnosis and treatment were performed. By conceptualising the interpersonal relations which flowed between patients, interviewing medical officers and onlooking members of staff within the meeting room, I examine how Gartnavel's medical officers used these meetings as an 'experimental stage' to evoke certain reactions from their patients. Secondly, after the interview with the patient was concluded, this chapter questions how the proceeding consultation process was productive of prognoses, diagnoses and plans for treatment. As previously stated, these meetings were places for debate and discussion, but, as this chapter shows, this logic did not always lead to consensual agreement. It is recognised that within staff meetings there was a shared, yet fluctuating, sometimes ambiguous use of language as Gartnavel's psychiatrists examined, communicated and constructed patients' medical records. Moreover, within the conceptual sphere of dynamic psychiatry, differing theories were discussed and built upon, ranging from Freudian to Kraepelinian and Meyerian psychiatry. Analysis of staff meeting transcripts shows Henderson endeavouring to stabilise the use of psychiatric nomenclature, and thereby negotiate a path between these different theoretical inputs. Thirdly, staff

meeting records are used to evidence the presence of patients whose voices were invariably silenced by organic disease, severe psychological disorder or through acts of resistance.

Chapter six, entitled 'Patient Narratives and the Articulation of Identities, Psyches and Spaces', foremostly concerns the construction of narratives, through which Gartnavel's patients expressed notions of experience, illness and identity. Patient testimony, produced in dialogue with medical officers during word association tests and therapeutic conversation, are initially quarried for meaning, exposing the narrative structures that framed and gave meaning to these dialogues. This is followed by the examination of patient narratives composed outside of immediate clinical encounters. Patient writings, which were filed away within correspondence folders and case note records, range from patients' dream diaries and correspondence - addressed to internal and external readers - to literary, poetic and autobiographical works. The inclusion of patients' self reported dreams, memories, imaginings and expressions of identity, somewhat disrupts the directional flow of analysis, which has hitherto been geared towards the application of case note taking techniques, allowing for alternative social, geographical and subjectively experienced worlds to emerge from case note records. Notions of illness and identity are refracted through a lens that looks outwards from the enclosures of Gartnavel's dormitories, day rooms, departments and rural grounds, evidencing the presence of those other phenomenological worlds, of the emotions, the delusions and disorders, which underwrote patient experience within and outwith the hospital environment. In doing so, this chapter sets the stage for a more in-depth, holistic, interpretation of the dynamic clinical encounter, which comprises the subject matter of the final chapter.

Chapter seven, entitled 'Faces of Lunacy, Theatres of Madness', uses a single case note record of a patient, named Miss Margaret Beaton, to trace the history of a diagnosis first termed moral insanity in the nineteenth century, but which was later re-classified by Henderson in the 1930s as belonging to the psychopathic states. In a period in which the so called 'moral imbecile' or 'moral defect' came into conflict with the law and was often placed within prison or confined to a mental hospital, Henderson went on to criticise society for making scant attempt to understand and to accommodate such individuals.⁷⁰ Beginning with the published case history of Miss Beaton, which appeared in Henderson

⁷⁰ A. A. W. Petrie 'Review of Psychopathic States: By D. K. Henderson M.D., Professor of Psychiatry, University of Edinburgh. Thomas W Salmon Memorial Lectures. Chapman and Hall Ltd., 1939' *The British Journal of Psychiatry* (1939) 85 p. 572.

and Gillespie's *Text-Book of Psychiatry* in 1927, I argue here that this patient gradually altered Henderson's understanding of such cases, and that this decisive interaction between patient and practitioner was a significant contributory factor to Henderson's radical revision of the diagnostic category.

To conclude I consider the status of psychobiological, or dynamic, psychiatry in the twenty-first century. While a number of psychiatrists argue for its re-evaluation and re-introduction into mainstream psychiatric practice, I argue for the historical value of a discourse form that enjoins nomothetic and idiographic forms of knowledge production.

CHAPTER ONE
‘THE WALLS OF MADNESS WERE BROACHED’
PATIENT CASE NOTE RECORDS, HISTORIOGRAPHICAL AND
METHODOLOGICAL ENQUIRY

The walls of madness were breached not so much by the mad attempting to get out as by the sane trying, through observation and dialogue, through medical and linguistic adaptability, to get in. Each case history represents one crack in the silence. Each account opens a small section of the inner world of the mad ...¹

Glasgow Royal Mental Hospital, in which the mentally ill were once housed, stands today as a solid and imposing stone structure on the site, still commonly known as Gartnavel. To walk around its parameters, and to survey its imposing Gothic architecture gives a sense of the power and influence the institution once held within the 19th and 20th century. But to step within its walls, walk along its corridors and climb its vast network of stairwells, one gradually enters into an atmosphere of decay and disuse.² Within its upper wards and throughout the whole of the East House, floors are beginning to collapse; paint flakes from the walls, and as the faint smell of dampness infuses the air the building bears the wounds of dismantlement. Records, equipment and the people who once made this a functioning mental hospital are now long dispersed, yet there remains a multitude of clinical records that bind this neglected building to the communities of patients, psychiatrists and medical staff who once resided within it.

When looking to the role of case note records in shaping the historiography of psychiatry/mental illness, we see that over the past thirty years, patient records have been uprooted from medical archives, as academia witnessed an exponential growth of interest in the ‘inner world of the mad’.³ For, as lunatic asylums and mental hospitals within nineteenth and twentieth-century Western societies came to dominate the process by which ‘madness’ was ‘split apart’ and spatially segregated from society,⁴ latter day scholars have

¹ Allan Ingram *The Madhouse of Language, Writing and Reading Madness in the Eighteenth Century* (London: Routledge, 1991) p. 71.

² Description based on a site visit conducted in September 2012, guided by Dr. Iain Smith. For a brief overview of the deterioration of asylum buildings see Andrew Scull *Social Order/ Mental Disorder. Anglo American Psychiatry in Historical Perspective* (Berkeley and Los Angeles: University of California Press, 1989) p. 215.

³ Berkenkotter *Patient Tales* p. 31. See also Andrews ‘Case notes, Case Histories’ p. 255.

⁴ Chris Philo *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales. The Space Reserved for Insanity* (New York: Edwin Mellon Press, 2004) p. 4.

endeavoured to breach institutional walls, and to retrieve from archival records those fragmentary utterances which attest to the ‘experience of madness’.⁵ As Jonathan Andrews wrote in the late-1990s, the rise of social history with its emphasis upon doing ‘history from below’, coupled with an emerging scholarly interest in uncovering the perspectives of asylum patients, ‘placed a higher premium on the value of case notes and individual histories for medical historians’.⁶ Looked upon by historians such as Guenter B. Risse and John Harley Warner as an ‘especially promising, yet little explored’ resource through which to explore patients’ perceptions of illness experience, the preservation of patient testimony within asylum case book records dating back to the nineteenth and twentieth century promised to unveil remarkable glimpses into the experiential worlds of asylum patients and practitioners.⁷ Over recent years scholars such as Gayle Davis have demonstrated how these sources may facilitate a ‘behaviourist’ approach to the history of medicine; one enabling scholars to take heed of Erwin Ackerknecht’s call to uncover ‘what doctors *did* in addition to what they *thought* and *wrote*’.⁸ Andrews, moreover, who has worked extensively on the records of Gartnavel in the nineteenth-century, demonstrates how committal papers, medical certificates, family questionnaires, personal correspondence, published case histories and post-mortem records may be used alongside patient case note records to explore the changing nature of clinical practice and patients’ experiences throughout the Victorian era.⁹

However, despite such sources having piqued the curiosity of social, medical and literary historians, deep disciplinary rifts between the ‘clinically qualified’ and the ‘historically trained’ continue to carve up their analysis.¹⁰ For, as Carol Berkenkotter writes, the distinguishing feature of case note records is that they are constructed from a ‘*double narrative*’: the story of the patient, told through his or her words, is subsumed within the linguistic devices and narrative patterns of clinical psychiatry, and therefore the analysis of such a ‘narrative within a narrative’ demands a highly interdisciplinary approach.¹¹ The sheer depth, breadth and complexity of case note records, argues Davis, necessitate that

⁵ Ingram *The Madhouse of Language* p. 4.

⁶ Andrews ‘Case notes, Case Histories’ p. 255.

⁷ Guenter B. Risse and John Harley Warner ‘Reconstructing Clinical Activities: Patient Records in Medical History’ *Social History of Medicine* (1992) 5, 2 183-205 p. 190.

⁸ Davis *The Cruel Madness of Love* p. 24.

⁹ Andrews ‘Case notes, Case Histories’ p. 255. See also Andrews ‘Death and the Dead-House in Victorian Asylums’.

¹⁰ Andrew Scull *Social Order/Mental Disorder. Anglo American Psychiatry in Historical Perspective* (Berkeley and Los Angeles: University of California Press, 1989) p. 132.

¹¹ Berkenkotter *Patient Tales* p. 2.

analysis be methodologically grounded and theoretically informed by not only the natural and social sciences, but also by the arts and humanities, and yet a ‘lacuna’ largely separates those who pursue social histories of psychiatry and psychiatric patients from those who are committed to unearthing a history of psychiatric knowledge.¹²

To place neatly the dividing line between social and clinical histories is an over simplification, yet one that became progressively ingrained within academia from the 1950s onwards. The ‘invasion’, writes Andrew Scull, of the social historian upon a field of research that was traditionally the preserve of sociologists and psychiatrists-turned-historians engendered ‘tense, if not openly hostile’ relations, which, until recently, negated interdisciplinary collaboration.¹³ For as the nomothetic approach, most commonly applied by sociologists and clinicians-turned-historians, studies events, persons and illnesses as ‘examples of some general law’, such a methodology often came into collision with the detailed empirical research, associated with literary critics and social historians, that focuses on subjective experience from a phenomenological stance.¹⁴

Indeed, such polarities were not only cleaving the scientific from the social, but were fermenting within such seemingly opposing camps, as the incursion of literary critics, feminist scholars, disillusioned psychiatrists and human geographers (to name but a few) resulted in an array of competing, often opposing, studies to emerge on themes of psychiatry, mental illness and mental institutions. Analysed within a variety of academic disciplines, some tell of organic disease and psychological disorder,¹⁵ while others speak of social movements and fluctuating power structures.¹⁶ Some delineate the lives of medical

¹² Davis *The Cruel Madness of Love* pp. 18, 30.

¹³ Ibid. The works of clinician-historians and socially orientated researchers upon patient case note and case history records have often occupied differing epistemological spheres, while present day professional commitments and political ideologies have further prevented interdisciplinary collaboration. Indeed, as contemporary politicised judgements have often shaped the orientation of historical research, this historiography critically reflects upon the impact contemporary usage of case note records has had upon their historical analysis.

¹⁴ Hawkins ‘A. R. Luria and the Art of Clinical Biography’ p. 6.

¹⁵ Allan Beveridge ‘Voices of the Mad, Patient’s Letters from the Royal Edinburgh Asylum, 1873-1908’ *Psychological Medicine* 27 (1997) 899-908.

¹⁶ David Rothman *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown and Co., 1971) Gerald N. Grob *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1973) - *Mental Illness and American Society, 1875-1940* (Princeton: New Jersey, 1983) Andrew Scull *Museums of Madness: the Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979). Thomas Szasz *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (London: Routledge, 1971).

professionals and their intellectual achievements,¹⁷ while others speak of patient populations and family dynamics.¹⁸ Increasingly scholars have explored the personal, subjective construction of a world in which human consciousness is experienced through the lens of ‘madness’.¹⁹

Such divergent areas of research have revealed fascinating, if sometimes conflicting insights into histories of Western psychiatry/mental illness, but in recent years these differing approaches have come under intense criticism as calls for greater interdisciplinarity are now at the forefront of scholarly enquiry. By highlighting the methodological ruptures that have previously divided the ‘clinically qualified and historically trained’, this select historiography paves the way for the delineation of my own methodology. Moreover, by paying close attention to contemporary psychiatric practices (such as the prevalence of the biomedical model in post WWII Western psychiatry) and political movements (such as the anti-psychiatry, feminist and de-institutionalisation movements of the 60s, 70s, 80s and 90s), I look to the wider ideological frameworks and political motivations which happened to steer the historiography of psychiatry/mental illness/mental institutions. In doing so, I seek to unite these multiple and, most notably, these *interconnected* scholarly perspectives, so as to explore, from an interdisciplinary perspective, the historical significance of Gartnavel’s dynamic case note records.

Historiographical overview, the question of disciplinary commitments

It is clear that to understand the history of psychiatry written by practitioners, it is a prerequisite to examine their own psychiatric commitments. It is equally clear that to

¹⁷ Cheryl McGeachan ‘Needles, Picks and an Intern Named Laing: Exploring the Psychiatric Spaces of Army Life’ *Journal of Historical Geography* (2013) 67-78. Allan Beveridge *Portrait of the Psychiatrist as a Young Man, the Early Writing and Work of R.D. Laing, 1927 – 1960* (Oxford: Oxford University Press, 2011).

¹⁸ Peter McCandless ‘A Female Malady? Women at the South Carolina Lunatic Asylum, 1828-1915’ *Journal of the History of Medicine* 54 (1999) 543-571.

¹⁹ Ida Macalpine and Richard Hunter ‘Introduction’ in Daniel Paul Schreber *Memoirs of My Nervous Illness* (London: W.M. Dawson and Sons Ltd, 1955) eds., trans., Ida Macalpine and Richard Hunter. Oliver Sacks *Awakenings* (1973; repr. London: Picador, 1991). Dale Peterson *A Mad People’s History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982). Roy Porter ed. ‘Introduction’ in John Haslam *Illustrations of Madness: Exhibiting a Singular Case of Insanity and a No Less Remarkable Difference in Medical Opinion: Developing the Nature of Assailment and the Manner of Working Events; with a Description of Tortures Experienced by Bomb-bursting, Lobster-cracking, and Lengthening the Brain.* (London: Printed by G. Hayden, 1810; repr. London: Tavistock Classics in the History of Psychiatry, Routledge, 1988). Roy Porter *The Faber Book of Madness* (London: Faber, 1991) - *Mind-Forg’d Manacles* (Cambridge, Massachusetts: Harvard University Press, 1987) - *A Social History of Madness: Stories of the Insane* (1987 repr., London: Phoenix Giants, 1996) see also *Women of the Asylum, Voices from Behind the Walls, 1840-1945* eds. Jeffrey Geller, Maxine Harris et al (New York: Doubleday, 2004).

understand the history of psychiatry written by historians, it is first necessary to examine the commitments of the historians.²⁰

While case notes and case histories played so central a role in the professionalisation of the psychiatric profession, it is unsurprising that the first historians to explore these records as sources of historical enquiry emerged from within the profession itself. During the 1950s, it was predominantly the psychiatrist-turned-historian, such as Ida Macalpine and Richard Hunter, who examined case notes and published case histories alongside the published works of nineteenth and early-twentieth century asylum patients and psychiatric practitioners. Influenced by the then fashionable Kleinian approach to the practice of psychiatry, Macalpine and Hunter retrospectively offered psycho-historical readings of patient narratives such as Daniel Paul Schreber's *Memoirs*, in which they explored the 'thinking, language, behaviour, delusions and hallucinations', which were understood to populate the 'mind of the schizophrenic'.²¹ As Sigmund Freud had defined Schreber's memoirs in 1910 as a 'case history' written by a patient suffering from paranoia, Macalpine and Hunter likewise underscored how such an autobiographical text surpassed in detail and 'completeness' case history records produced by the psychiatric profession.²² The overarching diagnostic construct of schizophrenia was explored from a deeply phenomenological perspective, and, in alignment with my own research, the narratives of the mentally ill were held as valid and insightful expressions of illness, experience and identity.

Nonetheless, psychiatry was, by the mid-1950s, moving towards a biomedical orientation, rooting the causation of mental illnesses in organic origins. Concurrently the literary style and psychoanalytic techniques used by Macalpine and Hunter to retrospectively evaluate individual patient narratives was increasingly rejected in their later publications. Rather, a

²⁰ Roy Porter 'Introduction' *Discovering the History of Psychiatry* (New York, Oxford: Oxford University Press, 1994) p. 12.

²¹ Porter 'Ida Macalpine and Richard Hunter' pp. 89-90.

²² As they retrospectively offered psycho-historical readings of patient narratives such as Daniel Paul Schreber's *Memoirs*, they used Schreber's original text to criticize the dominant Freudian reading of the case, which had hitherto dominated historical analysis. They contended that mental illness in such cases primarily emanated from disturbances of an internal reality, that is, 'in the patient's relation to himself, his mind and his body'. As they argued that the narratives of such psychotic patients offered psychiatrists the ability to 'understand the actions and speech' of other 'chronic psychotics', Schreber's *Memoirs* were translated in full. Prized as a window into the 'internal reality' of the mentally ill, Macalpine and Hunter wrote that such texts had 'the advantage of being complete to an extent no [published] case history taken by a physician can ever be'. Unabridged and unrevised by any 'intermediary between the patient and his psychosis' they argued that such patient testimonies enabled psychiatrists to 'make contact with' and thereby lessen the alienation of 'psychotic' individuals. Macalpine and Hunter 'Introduction' in Schreber *Memoirs of My Nervous Illness* pp. 22-25.

nomothetic perspective, which focused upon diseased bodies rather than sick minds, negated the value of individual patient testimony to the historical record. As Roy Porter remarked, Macalpine and Hunter's later analyses of famous 'mad' cases, such as King George III, 'deployed patient records to demonstrate the reality of mental illness rooted in authentic lesions of the brain and the nervous system, and metabolic disturbance'. From a biomedical perspective, patient testimony was afforded little meaning beyond that which correlated to organic disturbance.²³

For the Russian neurologist A. R. Luria, the rise of biomedicine in this period was seen to mark the loss of the 'humanistic impulse of clinical narrative in psychiatry and psychology'.²⁴ The richly detailed single subject case history that had regularly appeared within North American and British psychiatric publications in the first half of the twentieth century had little place in the era of biomedicine. As Porter was later to remark, this shifting perspective came to dominate histories of psychiatry produced in this period, as the commitments of contemporary psychiatric practice were deeply reflected in the methodologies and the questions posed by clinical historians.²⁵ Indeed, from the 1940s to the late 1960s, the growing authority of the biomedical model influenced the works of clinicians-turned-historians such as Gregory Zilboorg, and psychoanalytic historians Franz Alexander and Sheldon Selesnick. Offering 'Whig' histories of psychiatry, that focused upon the historical development of 'psychiatric ideas', their work, argued Mark S. Micale, relegated patients to the role of providing the 'raw' and 'inert material from which medical scientists drew their observations and practised their therapies'.²⁶

Nonetheless, while psychiatrists and medical historians steered towards modes of analysis that negated patient agency, disillusioned psychiatrists such as R. D. Laing were utilising the art of case history writing, precisely to destabilise the biomedical orientation of contemporary psychiatric practice. For Laing, his criticisms were directed towards the contemporary methods and specialised languages of the psychiatric profession. 'The standard texts' of psychiatry, wrote Laing, 'contain the descriptions of ... people in a

²³ Roy Porter 'Ida Macalpine and Richard Hunter' pp. 89-90.

²⁴ Berkenkotter *Patient Tales* p. 3.

²⁵ John Gach 'Thoughts Toward a Critique of Biological Psychiatry' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 690.

²⁶ Mark S. Micale 'Henri F. Ellenberger: The History of Psychiatry as the History of the Unconscious' in *Discovering the History of Psychiatry* eds. Micale and Porter p. 122. In reference to the original texts see for example Gregory Zilboorg and George W. Henry *A History of Medical Psychology* (New York: Norton, 1941) Franz Alexander and Sheldon Selesnick *The History of Psychiatry* (London: Allen & Unwin, 1967).

behavioural field that includes the psychiatrist', whose clinical languages 'isolated', 'depersonalised' and 'circumscribed the meaning of a patient's life to a particular clinical entity'.²⁷ Critical of many psychiatric professionals for having silenced the 'voice of unreason', by methods of medicinal, therapeutic, diagnostic and spatial control, Laing endeavoured to counterbalance such practices through his employment of existential and phenomenological psychologies. Advocating strongly that scholars explore the active role played by institutions and their practitioners in altering patients' psychological state, he used individual case studies to begin to understand patients' subjective experiences of 'being-in-the-world' so 'to make madness, and the process of going mad, comprehensible'.²⁸

Such an approach, which placed the experience of the hospital patient at the forefront of investigation, was in many ways complementary to the work of medical historian Henri F. Ellenberger, who used the published case histories and case note records of asylum patients to revise the theory-centric orientation of Whig histories of psychiatry, notably in his mammoth text *The Discovery of the Unconscious* in 1970. By unearthing the records of significant patients such as Bertha Pappenheim, whose case history was published under the pseudo name Anna O. in Freud and Josef Breuer's *Studies on Hysteria* (1895), Ellenberger highlighted the ways in which the official, published case history differed from that which was recorded in Breuer's own hand in the unpublished case note sources. Not only did he uncover discrepancies between the historical rendition and the unpublished case note materials, but through an in-depth analysis of Anna O.'s clinical biography, alongside that of over sixty published case histories, he constructed the concept of the 'paradigmatic patient', whose active performance within the clinical encounter shaped the history of psychiatry.²⁹ The centrality of case notes and case histories to Ellenberger's research, remarked Micale, imparted a novelistic quality to his work; one which vividly

²⁷ R. D. Laing *The Divided Self* (1960) quoted in Zbigniew Kotowicz *R. D. Laing and the Paths of Anti-Psychiatry* (London: Routledge, 1997) pp. 13-16.

²⁸ To explore further how distinct psychiatric spaces came to shape Laing's professional career, see the work of McGeachan. For instance, McGeachan quotes Laing as he recalled in his book *Wisdom, Madness and Folly* that one night, after being called to the padded cell of a disturbed patient, he 'went in and sat down to listen a bit more before he [the patient] would have to be stopped by injection. He calmed down. I stayed for half an hour or so... On the next few nights I stayed longer until I was almost 'hanging out' during the night with him in his padded cell'. By Laing entering into the patient's world, McGeachan states that Laing was able to form a 'completely different perspective' of his patient. Rather than watch a patient for signs of mental illness, he endeavoured to form an 'empathic relationship with someone 'other' to himself ...' See McGeachan 'Needles, Picks and an Intern named Laing' p. 76.

²⁹ Micale 'Henri F. Ellenberger' pp. 122-23.

portrayed individual patients' active participation in the developmental history of the psychiatric profession.³⁰

Social control theory

Despite the evident value of Ellenberger's historical research, such an approach was marginal in the 1970s. While the rise of biomedical psychiatry coincided with the disappearance of individual patient case histories within medical journals, the emergence of (versions of) social control theory likewise drew attention away from individual patient histories and medical encounters to the wider institutional aspects of psychiatry. Espoused by historians, philosophers, literary critics, disgruntled psychiatrists and sociologists such as David Rothman, Gerald Grob, Thomas Szasz, Andrew Scull and Michel Foucault,³¹ social control theses forcefully argued that asylums and contemporary mental hospitals were instruments of social control and vehicles for professional advancement. In many ways these studies were nomothetic in character, focusing upon macro-histories of moral, medical and architectural control, and therefore an 'embryonic historical geography' of the 'mad-business' took place, one that became anchored to neo-Marxist inspired ontologies.³²

For Scull, historical studies of the continually enlarging patient populations of nineteenth and early twentieth century asylums were, for example, explained in terms of power, deviance and class struggle; they were seen as the result of society's increasing inability/reluctance to absorb those defined as socially 'deviant' within industrialising, capitalist and rationalist social orders.³³ Foucault claimed within *Madness and Civilisation* that the physical chains which bound the mad within pre-Enlightenment times had been replaced in the practices of asylum reformists, notably Philippe Pinel and William Tuke, by a vast, yet subtle form of moral management, which silenced that which he envisaged as

³⁰ Philo *A Geographical History* p. 26.

³¹ For example see David Rothman *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Brown, 1971). Grob *Mental Institutions in America also Mental Illness and American Society, 1875-1940* (New Jersey: Princeton, 1983). Andrew Scull *Museums of Madness: the Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979). Thomas Szasz *The Manufacture of Madness*.

³² Philo *A Geographical History* p. 28. In making reference to a Neo-Marxist approach, I refer to the materialist approach, first advocated by Karl Marx (1818-1883) by which socioeconomic development is seen as a primary causative agent, steering the 'history of humanity'. See Anna Green and Kathleen Troup *The Houses of History, a Critical Reader in Twentieth-Century History and Theory* (Manchester: Manchester University Press, 1999) pp. 33-43.

³³ Andrew Scull 'Madness and Segregative Control: The Rise of the Insane Asylum' *Social Problems* 24 (1977) 337-351.

the authentic voice of madness.³⁴ Szasz, moreover, asserted that psychiatry was a ‘well-entrenched ideology’, which, by its privileged vocabulary, *manufactured* the *myths* that bound madness, within past and present societies, to the psychiatric profession.³⁵ This disparate collection of scholars - loosely grouped under the ‘social control’ label - therefore worked under a double impetus: to undermine past psychiatric theories and thereby attack the foundations of the contemporary psychiatric profession.

A critical backlash to social control

Such powerful and overarching theories were instrumental in shaping histories of madness, psychiatry and asylums throughout the latter half of the twentieth-century, but many argue these studies tended to homogenise the identities and experiences of patient populations and psychiatric practitioners. Many of the works produced within the framework of social control theory, argues Philo, ‘are frustrating in failing to indicate precisely whereabouts in ‘geographical space’ the economic, social and political moorings of mad-business ideas and practices are actually located’.³⁶ Through the application of too rigid a theoretical framework, such an approach rendered their analyses in many ways a-historical and insensitive to the specificities of the differing historical and spatial backdrops, against and through which the subjective histories of patients and practitioners were interspersed.³⁷ Moreover, such narratives prioritised economic, social and political models to the detriment of clinically orientated histories.³⁸

A text that exemplifies the tensions, provoking academics to problematise social control theory, was *Asylums*, published in 1961, written by the Canadian born sociologist Erving Goffman. Posing as a pseudo employee of a mental hospital, Goffman famously engaged in a participant-observational study in the 1950s where he analysed patients’ lives in St. Elizabeths Hospital in Washington, D.C. Based on his experiences at this institution, he

³⁴ Michel Foucault *Madness and Civilisation, a History of Insanity in the Age of Reason* trans. R. Howard (1961; repr. London: Tavistock, 1967).

³⁵ Szasz *The Manufacture of Madness* pp. xxii, 93. The case history of Anna O., Breuer’s ‘immortal patient’, was used by Szasz to exemplify how psychiatric historians could omit and censor their own past to enforce the power that they contemporarily yielded. The underlying principles of the talking cure used by psychoanalysts to treat patients such as Anna O. was noted by Szasz to have originated *not* from the practitioner, but from the patient whose voice, he argued, was dominated and devalued within published case histories.

³⁶ Philo *A Geographical History* pp. 28-29.

³⁷ *Ibid*, Philo remarks that this is particularly true of Szasz who ‘turns the categories of ‘Institutional Psychiatry’ and the ‘Inquisition’ into highly abstract and monolithic edifices with few moorings in the historical record, let alone in the soils of geography’ p. 63 note 305.

³⁸ Porter ‘Introduction’ *Illustrations* p. 11. See also Davis *The Cruel Madness of Love* p. 17.

produced a damning portrayal of contemporary mental hospitals and the social situation of their patients. While Goffman considered the history of asylums in a fleeting way, his comparison of the rise of madhouses, asylums and mental hospitals to the rise of ‘personal-service occupations’ from the mid-eighteenth-century onwards, established a radically different framework from which to explore histories of psychiatry, asylums and their patients.³⁹ As Porter remarked, Goffman offered an analysis of hospital patients which went beyond those merely charting the repression of those considered mentally ill, to highlighting instead the ‘survival strategies of the inmates of total institutions’, their methods of ‘resistance, and capacity to play the system’.⁴⁰ Goffman showed that while patients moved through the asylum system a ‘paper shadow’ of ‘case file[s]’ and ‘receipts detailing what ... [was] done to and by the patient’ was constructed by multiple staff members.⁴¹ Particularly relevant to my own work on the case note record, he highlighted how such an array of administrative procedures and textual artefacts combined to create a patient’s medical identity.⁴²

Despite the overwhelming success of *Asylums*, researchers, most notably practicing in neurology and psychiatry, criticised Goffman for conflating the history of Western asylums with that of prisons, monasteries and concentration camps, which he portrayed as monolithic structures, united by their characteristics as ‘total institutions’. Goffman’s homogenising description of ‘total institutions’ as places in which inhabitants were dispossessed of their normal social roles, separated from society, and where identities were slowly destroyed through processes of humiliation, alienation and mortification, was highly criticised by psychiatrists Miriam Siegler and Humphry Osmond.⁴³ They argue *Asylums* constructs a vision of the mental hospital resembling a ‘terrifying world ... [as he]

³⁹ ‘Personal-service occupations’ are defined by Goffman as ‘one whose practitioner performs a specialized personal service for a set of individuals where the service requires him to engage in direct personal communication with each of them and where he is not otherwise bound to the persons he serves ... turning to the medical version of the [personal service occupation] ... Our giving our bodies up to the medical server, and his rational-empirical treatment of them, is surely one of the high points of the service complex’. Erving Goffman *Asylums, Essays on the Social Situation of Mental Patients and Other Inmates* (1961; repr. London: Penguin Books, 1991) pp. 281-305.

⁴⁰ Roy Porter ‘The Patient’s View, Doing Medical History from Below’ p. 194.

⁴¹ As Goffman writes ‘[t]he case record plays a role here. It provides a means of systematically building up a picture of the patient’s past that demonstrates that a disease process had been slowly infiltrating his conduct until this conduct, as a system, was entirely pathologised. Seemingly normal conduct is seen to be merely a mask or shield for the essential sickness behind it. An all over title is given to the pathology, such as schizophrenia, psychopathic personality ... in practice these categories become magical ways of making a single unity out of the nature of the patient – an entity that is subject to psychiatric servicing’. Goffman *Asylums* p. 326.

⁴² *Ibid* p. 74.

⁴³ *Ibid* p. 30.

skilfully evokes ... fear and horror'. He is said to have 'achieved this effect by the simple device of describing the procedures in mental hospitals without ever discussing the illnesses from which the patients are suffering'.⁴⁴ The clinical history of psychiatry, mental illness and asylum care, Siegler and Osmond observe, was notably absent within Goffman's work.

As Gerald Grob demonstrates, such debates were acutely shaped by contemporary controversies playing out within public health policy. Anti-psychiatric critiques were pushing towards the process of deinstitutionalisation, and therefore the politics of psychiatric hospital closure were inevitably reflected by, and indeed interacted with, such provocative publications.⁴⁵ Throughout the collection of scholarly works labelled under the 'social control movement'; social, political and economic frameworks were given preference over the examination of distinct clinical entities, arguably reflecting the concerns of contemporary political debate. As 'total institutions' were recognised by Goffman to dispossess individuals of their social identities and to reshape patients' sense of self according to differing medical models, Siegler and Osmond contend that the actual variance of patients' personal experiences of mental illness within differing institutions was negated. Social control theorists arguably lacked an in-depth engagement with the many ways in which patients' internal worlds are shaped by disease, or by the plethora of mental disturbances which originate from the complex interplay between patients' minds-bodies and the medical interventions and wider cultural backdrops against which their experiences are set. As Edwin R. Wallace contends:

Such one-sided history writing reflects lack of familiarity with the suffering schizophrenics, treatment-refractory depressives and bipolars, "organic" patients, and others who made up much of the pre-1960s state hospital population. It betrays as well a complete lack of recognition of the extent to which certain disorders destroy capacities for judgement and reality testing, rendering "dumped" patients vulnerable to exploitation, abuse, and coercion ("social control") in the outside world.⁴⁶

⁴⁴ Miriam Siegler and Humphry Osmond 'Goffman's Model of Mental Illness' *British Journal of Psychiatry* (1971) 119, 419-421 p. 442.

⁴⁵ I use the term 'deinstitutionalisation' to refer to the transference of mental patients from state run facilities to that which Roy Porter and Mark S. Micale term the 'so-called community health centres'. Porter 'Introduction' *Discovering the History of Psychiatry* p. 21.

⁴⁶ Edwin R. Wallace, 'Historiography, Philosophy and Methodology of History, with Special Emphasis on Medicine and Psychiatry; and an Appendix on 'Historiography' as the History of History' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 44.

Social control theorists' ground-breaking challenges to contemporary asylum care, combined with their efforts to undermine the historical origins and (therefore) present day legitimacy of the psychiatric profession, were highly influential, but it provoked the indignation, not only of practising psychiatrists, but also of professional historians, wary of the imposition of present day 'politicised judgements' upon past historical periods.⁴⁷

One group of emergent historians, using case note records directly to counterbalance the macro-histories of social control theorists, emerged from within the feminist movement. Many scholars were criticising social control theorists, not only for their uncompromising vision of the asylum regime, but also for their failure to look at gender, class, cultural and geographical specificities of asylum care. As Nancy Tomes claims, in the 1970s second wave feminist-asylum-historians revealed a much more complex and often ambiguous evaluation of the asylum. Through the analysis of case note records, ward diaries and correspondence materials, nineteenth-century Western asylums began to be envisaged as a place not only of confinement and control, but also of refuge and respite.⁴⁸

The use of case note records within such meticulously researched histories created a notable counter-narrative to that of the social control thesis, but such studies did not attract the same degree of recognition or publicised controversy, and it was once again the canonical works of Foucault which sparked a radical re-envisioning of the history of psychiatry/mental illness. In the wake of academic criticism pointing towards the shortcomings of social control theory, Foucault departed from a tangential alignment with the works of Goffman, Rothman and Szasz, and developed a more nuanced approach to the subject of 'madness'. A decade previously Foucault had written in *Madness and Civilisation* (1967 first British translation) of a 'gigantic moral imprisonment' that silenced the strange syntax and 'stammered, imperfect words' which characterised the voices of the 'mad'.⁴⁹ But such a grand and overarching theory, presupposing the existence of an essential 'mad' language anchored to a deep metaphysical, almost objective existence of 'madness', was at once rejected within *The Archaeology of Knowledge* (1972).⁵⁰ In reply to

⁴⁷ H. C. E. Middleford 'Madness and Civilization in Early Modern Europe: a Reappraisal of Michel Foucault' *After the Reformation: Essays in Honour of J. H. Hexter* ed. Barbara. C. Malament (Manchester: Manchester University Press, 1980) pp. 247-265.

⁴⁸ Nancy Tomes 'Feminist Histories of Psychiatry' in *Discovering the History of Psychiatry* eds. Mark S. Micale and Roy Porter (New York, Oxford: Oxford University Press, 1994) p. 359.

⁴⁹ Michel Foucault *Madness and Civilization* (Oxon: Routledge, 2001) p. xii.

⁵⁰ Philo *A Geographical History* p. 67, also note 146, in reference to Michel Foucault *The Archaeology of Knowledge* trans A. M. Sheridan Smith (London: Tavistock Publications, 1972).

criticisms made by Jacques Derrida who problematised this core assumption, that madness has an invariable, essential language, Foucault's response in 'My Body, this Paper, this Fire' was to further reconceptualise madness as something which was perceived, defined and performed within distinct historical, spatial and linguistic arenas.⁵¹ When Foucault delivered his *Psychiatric Power* lectures at the Collège de France in 1973, the concept of 'madness' began to be stripped down - past its representational core; past the 'medical models', 'images, fantasies, and knowledge[s]' which constituted differing 'perception[s] of madness' - so that it could be 'grasped' at the point where such perceptions were formed. It was from this new theoretical platform that his seminal text *Discipline and Punish* (1975) engaged, head on, with the role of the case note record in constituting the identity of the asylum patient, and of making possible the imposition of psychiatric power:

... the examination, surrounded by all its documentary techniques, makes each individual a 'case': a case which at one and the same time constitutes an object for a branch of knowledge and a hold for a branch of power.⁵²

Foucault's examination, in *Discipline and Punish*, of the role of the case record in constituting the individual patient was – in contrast to his more canonical concepts - to make a rather more low-key impact upon wider historical/philosophical studies.⁵³ Nonetheless, I argue that by returning to this little quoted component of *Discipline and Punish*, Foucault may be recognised as opening up a conceptual space in which to re-envisage the formation of patient identities and conceptions of 'madness'.⁵⁴ For as Foucault envisaged the psychiatric examination as a process by which individual patients entered into the field of psychiatric knowledge, he probed the central problematic, reiterated time and again, of the somewhat paradoxical notion of a 'science of the individual'. Foucault observed that the 'examination, surrounded by all its documentary techniques, makes each individual a "case"'.⁵⁵ The 'problem of the entry of the individual description, of the cross-examination, of anamnesis, of the 'file' into the general functioning of scientific discourse', was recognised to emanate from an innate tension; by which individual patients are at once 'described, judged, measured, compared with others' so they may be precisely

⁵¹ G. P. B. 'Cogito Incognito: Foucault's 'My Body, This Paper, This Fire' *Oxford Literary Review* (1979) 4, 5-8 p. 6.

⁵² Foucault *Discipline and Punish, the Birth of the Prison* p. 191.

⁵³ The architectural design of the Panopticon style prison, where each prisoner is locked in a cell - potentially and knowingly under constant surveillance - was used by Foucault to demonstrate the functioning of power through architectural design and psychological, as well as physical, disempowerment. See Foucault *Discipline and Punish, the Birth of the Prison* pp. 195-228.

⁵⁴ Anderson 'The Case of the Archive'. See also Suzuki 'Framing Psychiatric Subjectivity'.

⁵⁵ Foucault *Discipline and Punish* p. 191.

understood through their ‘very individuality’, and yet ‘simultaneously corrected, classified, normalized or excluded’ so that their identities became fixed, so they became an object transfixed by the ‘medical gaze’ of the psychiatric profession.⁵⁶ Writing from the premise that the formation of the psychiatric case note record functioned to ‘capture and fix’ individuals in a ‘network of writing’, Foucault hypothesised - somewhat akin to Sacks’ distinction of nomothetic and idiographic constructions of the case note record - that such records constituted the patient, firstly as a:

describable, analysable object, not in order to reduce him to ‘specific’ features, ... but in order to maintain him in his individual features, in his particular evolution, in his own aptitudes or abilities, under the gaze of a permanent corpus of knowledge; and, secondly, [to constitute the patient through] a comparative system that made possible the measurement of overall phenomena, the description of groups, the characterization of collective facts, the calculation of the gaps between individuals, their distribution in a given ‘population’.⁵⁷

What makes possible this paradoxical formation of the psychiatric patient whose *individual identity* is at once magnified and fixed as an object of psychiatric knowledge/power, and yet simultaneously negated through the imposition of a group identity, a shared diagnosis and a shared fate of social exclusion, concluded Foucault, is the *written report*. The centrality of case note records to Foucault’s thesis is clear, as such records - seen to facilitate ‘mechanisms of examination’ administration and legal authority – are understood to constitute patient identities within clinical settings. This I find a valuable conceptual framework from which to envisage the relations of power and knowledge that formed patients’ clinical identities.

Within such a thesis, however, Foucault portrayed the hospital patient in a predominantly passive relationship to that of the practitioner, whose power to define and delimit the identity of the patient rested upon his ability to construct the ‘case’ report. I do not unquestioningly agree with this component of Foucault’s thesis; rather, I take influence from Foucault’s much later published works on the subject of psychiatric power. In these works, Foucault’s somewhat static representation of the socially marginalised was replaced by an exploration of the fluctuating, and interdependent states of power and authority that flowed within differing cultural and institutional arenas. Foucault established that, as the

⁵⁶ Ibid.

⁵⁷ Ibid pp. 185, 189-90.

psychiatrist's ability to construct the aetiology of mental illness became increasingly reliant upon their analysis of patients' 'memories, intimate disclosures' and forms of 'self-examination', the power of the profession to define the individual subjectivity of the psychiatric patient ultimately rested with the patients' willingness to enter into a system of 'confession'.⁵⁸ Rather than picture the asylum or mental hospital as an institution which, by its regularity and rules, created uniform patient populations and suppressed and silenced this vague and unproductive notion of the 'mad', Foucault provoked his readers to question more intently how 'imbalances of power' were dispersed *between* patients, practitioners and wider judicial and moral mechanisms of control.

Linguistic turn

It was to the published case histories, rather than the raw materials of the case note record, that a number of feminist scholars, interested in such Foucauldian conceptualisations of power, authority and identity, turned in the 1970s and 80s. Inspired by the radical historicism of Foucault, the psychoanalytic criticism of Lacan, and processes of Derridan deconstruction, cultural and literary studies re-appropriated a critical hermeneutics of illness to study histories of mental illness/psychiatry.⁵⁹ Developments in psychoanalytic theory, gender analysis and semiotic enquiry saw feminist histories of psychiatry gradually move away from the analysis of institutions and specific historical actors, and towards the larger 'discursive formations' of power/knowledge in which the psychiatric profession operated.⁶⁰ Rather than uphold the aforementioned stances taken by social control theorists, they began by examining 'the linguistic and symbolic systems' within which patients and psychiatrists operated. By exploring how binary oppositions within Western culture such as 'male-female' were embedded within everyday language, they questioned how the gendering of language shaped the ways in which patients and practitioners articulated, and indeed constructed, concepts of madness/mental illness.⁶¹

By the early 1980s a number of feminist scholars used such discursive frameworks of analysis to explore how myth and metaphor underscored the content of Freud's clinical

⁵⁸ Michel Foucault 'The Dangerous Individual' in *Politics, Philosophy, Culture, Interviews and Other Writings 1977-1984* trans. Alan Sheridan, ed. Lawrence D. Kritzman (New York, London: Routledge, 1990) pp. 126-27, 151.

⁵⁹ David E. Shuttleton *Smallpox and the Literary Imagination 1660-1820* (Cambridge: Cambridge University Press, 2007) p. 11.

⁶⁰ *Ibid* p. 261.

⁶¹ *Ibid*, for example see the work of Carroll Smith-Rosenberg on 'The Hysterical Woman' *Social Research* 39 (1972) 652-678.

case histories. Derridian methods of deconstruction were applied to the analysis of case histories, but arguably the most decisive development, shaping feminist histories of mental illness and psychiatry, became their uptake of Foucauldian conceptualisations of power. Power, it was argued, existed not as the direct exercise of domination by psychiatrists, but rather as discursively dispersed, operating through a pervasive system of ‘perception’, ‘thought’ and ‘language’ in which ‘both doctor and patient acted’. Case histories became the vehicle from which to explore the application of power within such discursive systems,⁶² and in 1985, literary historians Charles Bernheimer and Claire Kahane deployed this conceptual framework of power and gender to re-read the case history of Freud’s ‘Dora’.⁶³ In an edited collection of works entitled *In Dora’s Case*, they explored the active role of the psychoanalyst in shaping the meaning of patient testimony. Kahane critiqued what she saw as Freud’s desire for, identification with and yet repudiation of, femininity within his analysis of Dora. Literary critic Dianne Hunter likewise rejected the legitimacy of that which she defined as the inherent patriarchal dimension of psychoanalytic analysis. By re-evaluating the stammering, made up words and sign language used by Dora, Hunter reframed Dora’s narrative. Through her analysis of the cultural context in which Dora spoke, she argued that the voice of Freud’s most famous patient spoke of a deliberate regression from a patriarchal language to a mode of expression that was ‘pre-discursive’, wilfully subverting the cultural order.⁶⁴ Such texts, while inserting a radical feminist critique of psychoanalytic (rather than asylum) case histories, reflected not only a revision of the past, but arguably represented these scholars’ close filiality to the concerns of contemporary feminist movements.⁶⁵

Pathographies, and new neurological perspectives

It may be said that in the 1970/80s, when madness/mental illness was beginning to be re-conceptualised in such fluid and destabilising terms, wherein the interpersonal relations between patient and practitioner became a central component of analysis, a movement, emanating from within the psychiatric profession, once again endeavoured to conjoin the biomedical picture of mental disease with a wider analysis of the social, cultural and

⁶² Tomes ‘Feminist Histories of Psychiatry’ p. 361.

⁶³ ‘Dora’ is the pseudonym given to Freud’s patient, Ida Bauer, whose case history was published in 1905 as *An Analysis of a Case of Hysteria*.

⁶⁴ Dianne Hunter ‘Hysteria, Psychoanalysis and Feminism: The Case of Anna O’ *Feminist Studies* 9, 3, (1983) 465–488.

⁶⁵ Roy Porter and Mark S. Micale ‘Introduction to the History of Psychiatry and Its Histories’ in *Discovering the History of Psychiatry* eds. Roy Porter and Mark S. Micale (Oxford: Oxford University Press, 1994) p. 8.

interpersonal relations shaping illness experience. Through the works of Russian neurologist A. R. Luria and the British-American neurologist Oliver Sacks, a distinct countertrend emerged to the nomothetic studies that dominated psychiatric practice and sociological analysis. As Sacks so fervently argued below, their work critiqued the depersonalising nature of the modern published case history, while endeavouring to re-establish the legitimacy of the narrative case history:

There is no ‘subject’ in a narrow case history; modern case histories allude to the subject in a cursory phrase (‘a trisomic albino female of 21’), which could as well apply to a rat as a human being). To restore the human subject at the centre – the suffering afflicted, fighting, human subject – we must deepen a case history to a narrative or tale: only then do we have a ... real person, a patient, in relation to disease – in relation to the physical.⁶⁶

Contemporary divisions between nomothetic and idiographic paradigms were recognised by Luria and Sacks to offer partial, incomplete insights into neurological disorder. They wanted to understand the patient ‘both as a product of neurological functions and as a fully constituted self living in a particular context’, necessitating a discourse form which combined both forms of knowledge production.⁶⁷ Sacks located this ideal discourse form in ‘biography’. Seeking to reinvigorate interest in the art of case history writing, the use of patient biography, later termed ‘pathography’, challenged the impersonal, biomedical orientation of scientific writing. With works such as Luria’s *The Man with the Shattered World* (1972) and Sacks’ *Awakenings* (1973) and *The Man Who Mistook His Wife for a Hat* (1985), neurological studies, which usually focused upon reductionist, monistic explanations of human perception, were incorporated with studies of subjective experience. Through the use of a narrative framework, which evolved around the life stories of individual patients suffering from neurological disorders, Luria and Sacks transcended the divide between nomothetic and idiographic conceptions of the mind. They created what Clifford Geertz termed a ‘blurred genre’: that is, ‘a mixing of the intellectual conventions of various disciplines’ which fundamentally re-envisioned the relations between the sciences and humanities.⁶⁸

⁶⁶ Oliver Sacks *The Man Who Mistook His Wife For a Hat* (London: Picador, 1986) p. 39.

⁶⁷ Debra Journet ‘Forms of Discourse and the Sciences of the Mind: Luria, Sacks, and the Role of Narrative in Neurological Case Histories’ *Written Communication* (1990) 7 171-199 p. 179.

⁶⁸ *Ibid* p. 182.

Despite evident interest aroused by such publications, '[f]ew ... clinicians' during this period, wrote Anne Husanker Hawkins, 'would want to compromise their objectivity ... by introducing literary dimensions of form and style' to contemporary medical publications. Moreover, from within the circles of literary criticism, the novelistic quality of Sacks' research attracted positive reviews, and yet, most psychiatric case histories dating back to the nineteenth and early twentieth century were treated as forms of 'non-literature' by literary critics, and excluded from literary-historical analysis.⁶⁹ Nonetheless, in the decades to come, the narrative 'pathographies' of Luria and Sacks paved the way for a more 'holistic and interpretative' framework to be implemented, as scholars, interweaving nomothetic and idiographic forms of knowledge production, strove to attain a greater 'understanding [of] human mental processes'.⁷⁰

Voices of madness and histories from below, social and cultural perspectives

While Luria and Sacks, alongside notable feminist and medical historians, highlighted the significance of individual patient histories to our understanding of the mind and mental illness, a substantial shift in scholarly interest across the 1980s and 1990s saw literary theorists, alongside social and cultural historians, endeavouring, firstly to give voice to the 'mad', and secondly to embed these narratives within the social, historical and linguistic contexts from which they originated. Akin to the ideographic approach, scholars such as Dale Peterson, Roy Porter, Jeffrey Geller, Maxine Harris and Elaine Showalter collated published records of individual 'mad voices' so as 'simply and quite literally [to] see what they had to say'.⁷¹ Collected from diary entries, correspondence records, published case histories and the reported speeches of well-known and lesser known individuals considered 'mad' by their contemporaries, these 'mad voices' were set against the biographical, social, theological and literary contexts in which they were produced.⁷² In their efforts to uncover the voices of individuals who were socially marginalised - due to their unsettling behaviours, unconventional views or unusual visions, dreams, or delusions - the written testimonies of individuals such as the medieval 'prophet' and 'visionary' Margery Kempe, Whig M.P. Goodwin Wharton, twentieth-century actress Elizabeth Farmer and the author

⁶⁹ Hawkins 'A. R. Luria and the Art of Clinical Biography' p. 1.

⁷⁰ Journet 'Forms of Discourse and the Sciences of the Mind' p. 172.

⁷¹ Porter *Mind-Forg'd Manacles* p. 1.

⁷² Peterson *A Mad People's History of Madness*. Porter *The Faber Book of Madness*, also *Mind-Forg'd Manacles*, also *A Social History of Madness: Stories of the Insane*.

Virginia Woolf were all used to highlight the shifting dynamics by which human consciousness, behaviours and mannerisms were judged normal or abnormal.⁷³

Such works, while illuminating in their retrieval of ‘mad voices’ from archival and published sources, met differing degrees of criticism. In the case of Showalter, published narratives of psychiatric patients, such as that of Virginia Woolf and case histories of asylum patients such as the social libertine Edith Lanchester, were used to promote the hypothesis that madness was overwhelmingly constructed as a ‘female malady’ in nineteenth and early-twentieth century Western societies. Arguing that female protest against patriarchal definitions of femininity was manifest in women’s appropriation of the hysterical role, hysterical symptoms such as mutism, bodily paralysis or the overt expression of sexual desire were construed by Showalter as forms of ‘body language’ that spoke of women’s resistance to contemporary gender roles.⁷⁴ Although Showalter was lauded for her efforts to reinsert the voice of female patients into the mainstream historical record, thereby highlighting what was distinctive about female experiences of mental illness and medical treatment, criticisms from scholars such as Scull asserted Showalter’s overarching hypothesis - that madness, even in men, was preponderantly recognised as a feminine disorder - could not be upheld by statistical evidence found within asylum records.⁷⁵ Likewise sociologist Joan Busfield stated that the focus paid by Showalter to the social situation of women and cultural representations of female madness such as the mad ‘Ophelia’, or the ‘crazy Janes and crazy Kates’, blinkered Showalter to cultural representations of madness and masculinity such as the ‘mad genius’, the criminal or the masturbatory insane.⁷⁶ Moreover, Showalter’s failure to take into account the differential mortality statistics between men and women, argues Busfield, alongside not having calculated the average length of stay of male and female patients, or having related her findings to local population data, meant that her interpretation of asylum records distorted patient population statistics.⁷⁷

Criticisms were likewise aimed towards Porter’s *A Social History of Madness*, with the thick descriptive style of Porter’s work being criticised for ‘recapturing, rather than

⁷³ Porter *Mind-Forg’d Manacles* p. 259.

⁷⁴ Elaine Showalter *The Female Malady, Women, Madness and English Culture, 1830-1980* (London: Virago, 1987) p. 172.

⁷⁵ Andrew Scull ‘Dazeland’ *London Review of Books* 9 (1987) 19 114-15.

⁷⁶ Joan Busfield ‘The Female Malady? Men, Women and Madness in Nineteenth Century Britain’ *Sociology* 28 (1994) 259-277 p. 269.

⁷⁷ *Ibid* p. 268.

recovering' the voices of asylum patients.⁷⁸ Social and cultural historians certainly did much to reinsert the individual histories of patients into the historical record; but, as the analysis of patient case note records was largely absent from the work of Peterson, Showalter, Geller, Harris and Porter, the voices of 'the mad' from *within* mental hospitals and clinical encounters was notably absent.⁷⁹ However, one notable exception, bridging the gap between published works and the raw materials of the case note record, must be mentioned.

In 1988, Porter edited and introduced an edition of the 1810 text *Illustrations of Madness*,⁸⁰ widely known to historians of psychiatry as the 'first book-length case history of the delusions of a [schizophrenic] patient'.⁸¹ This early form of case history, written by Bethlem Hospital apothecary surgeon John Haslam, is a remarkable resource from which to explore a practitioner's attempt at reproducing the fantastical world of his patient.⁸² Its full title, which announces the controversial medical opinion surrounding this case, as well as describing some of the 'tortures' reportedly voiced by his patient, is characteristic of a source that reveals much as to the cultural, legal, medical and phenomenological worlds, which contextualised the case history:

Illustrations of Madness: Exhibiting a Singular Case of Insanity and a No Less Remarkable Difference in Medical Opinion: Developing the Nature of Assailment and the Manner of Working Events; with a Description of Tortures Experienced by Bomb-bursting, Lobster-cracking, and Lengthening the Brain.

For Porter, who argued that 'medical history ought centrally to be about the two-way encounters between doctors and patients', *Illustrations* provided one of the surest documents with which to employ his often quoted method of 'Doing Medical History from

⁷⁸ Porter *The Faber Book of Madness*. For remarks on its public reception see Jonathan Andrews 'Grand Master of Bedlam: Roy Porter and the History of Psychiatry' *History of Science* 41 (2003) p. 270.

⁷⁹ In alignment with feminist historians such as Bernheimer and Kahane, Porter's *A Social History of Madness* did use the published case histories of one of Freud's patients, known most commonly as the 'Wolf Man', to critique psychoanalytic constructions of patient identities. By contrasting Freud's interpretation of the Wolf Man's childhood memories of seduction and his boyish dream of bushy tailed white wolves, against the Wolf Man's own recorded testimonies which were vocalised outside of the clinical encounter, the voices, languages and the imaginings of both patient and practitioner were explored with the effect that the legitimacy of Freudian psychoanalysis was undermined and the interpretive framework of Freud's published case histories subtly mocked. See Porter *A Social History of Madness* p. 223.

⁸⁰ Porter 'Introduction' in *Illustrations of Madness*.

⁸¹ Peter K. Carpenter 'Descriptions of Schizophrenia in the Psychiatry of Georgian Britain: John Haslam and James Tilly Matthews' *Comprehensive Psychiatry* 30, 4 (1989) p. 332.

⁸² Haslam *Illustrations of Madness*: cited in Carpenter 'Descriptions of Schizophrenia' p. 334.

Below'.⁸³ Since Haslam quoted verbatim sections of a manuscript written by his patient, James Tilly Matthews, during the period of his confinement, the narratives of both patient and practitioner produced within institutional confines were bound together in *Illustrations*. Reproduced by Haslam to evidence Matthews' lengthy descriptions of torture and persecution, the collation of these two distinct, yet intertwining, narratives enabled Porter to situate their writings within the confines of the asylum, as well as the wider context of cultural, political, inter-personal and professional relations from which *Illustrations* emerged.⁸⁴

Such a rare source, detailing Matthews' belief that 'in some apartment near London Wall there is a gang of villains profoundly skilled in Pneumatic Chemistry who assail him by means of an Air Loom', attracted the attention of scholars across the disciplinary divides. Psychiatrists Dennis Leigh and Peter K. Carpenter, sociologist Andrew Scull, literary critics/historians Allan Ingram and Carol Berkenkotter, and Porter himself, were each pulled towards this in-depth account of delusion/persecution. Yet, despite their shared interest, there continued a lack of interdisciplinary collaboration within these works.⁸⁵ Retrospective diagnostic analyses, performed by Carpenter, may, for instance be contrasted with the thick descriptive accounts of Berkenkotter. 'The publication of this case is remarkable for the detail with which it describes thought insertion and withdrawal', remarked Carpenter, 'as well as passivity experiences and third-person auditory hallucinations coupled with a chronic elaborate delusion of persecution'.⁸⁶ Compare this with Berkenkotter's account of the 'raw material' of Matthew's 'thought-system', of the 'various tortures in which his persecutors engaged, the mysterious Air Loom with its fantastical powers ... the magnetic fluid that impregnates his (and others') "vitals"', all of which 'suggests the preoccupation at the end of the eighteenth century with a "universal fluid" and with fantastical machines and the wonders of electricity', and we hear how such widely divergent disciplinary thought styles separate the sciences from the humanities.⁸⁷

⁸³ Porter 'The Patient's View' p. 175.

⁸⁴ Haslam *Illustrations of Madness*. See also Berkenkotter *Patient Tales* p. 32.

⁸⁵ Dennis Leigh *The Historical Development of British Psychiatry Vol. 1*. (Oxford: Pergamon, 1961). Carpenter 'Descriptions of Schizophrenia' pp. 332-338. Andrew Scull, Charlotte MacKenzie, and Nick Hervey eds. *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton: Princeton University Press, 1996). Porter 'Introduction' *Illustrations of Madness*.

⁸⁶ Carpenter 'Descriptions of Schizophrenia' p. 334.

⁸⁷ Berkenkotter *Patient Tales* p. 47.

It is to Allan Ingram's study of *Illustrations* that we find a methodology seeking to breach these disciplinary divides. By learning how to read 'mad writing' by contextualising it within the 'system of grammar' and the 'social system' in which it was first expressed, Ingram states that we may peer beneath Matthews' imaginings of "Thigh-talking" and "Thought-making" to re-read such texts as expressive of pain, bodily alienation and ontological insecurity. For, although these emotions are expressed in implausible terms, the story is read as a response to the irrational, alien emotions, which may derive from mental illness.⁸⁸

The illness narratives

Despite such rare examples attracting scholars across the disciplinary divides, there remained a large-scale absence of case note records and case histories in social histories of madness across the 1980s and the early 1990s. Saying this, within the burgeoning interdisciplinary sphere of the medical humanities, there emerged an exception to this scholarly trend.⁸⁹ Case notes and case histories began more thoroughly to be identified as sources of historical enquiry, and this movement coincided with contemporary clinicians reassessing the value of the case history. Books such as *The Illness Narratives*, authored by psychiatrist and anthropologist Arthur F. Kleinman, marked for many in the medical humanities a turning point for interdisciplinary collaboration that bridged the paradigmatic gap between the sciences and humanities. A generation of clinicians, disenchanted by the limitations of biomedical training, wished to study illness not only as the physiological determinant of disease, but to engage further with illness sufferers upon an empathic, phenomenological level.⁹⁰ Illness narratives, articulated by patients, were seen to create a 'symbolic network linking body, self and society', and therefore the role of the clinician, argued Kleinman, was to uncover such narratives through the lost art of clinical case history taking. Through the application of a semiotic epistemology, he explored the 'plot lines', 'core metaphors and rhetorical devices' that shaped stories of illness, suffering and healing told by patients.⁹¹ By learning to interpret patient stories, Kleinman supposed we are better equipped to understand how 'physiological processes, meanings, and

⁸⁸ Ibid p. 113.

⁸⁹ The work of the medical humanities, which arguably emerged as a distinct specialism in North America some 30 years before it took off in Britain, stemmed from scholars who were desirous to expose medical practitioners to the humanities, so to 'reunite ... technical and humanistic knowledge' of the 'human' within a 'common mode of enquiry'. See David Greaves and Martyn Evans 'Medical Humanities' *Journal of Medical Ethics: Medical Humanities* (2000) 26 1-2 p. 1.

⁹⁰ Kleinman *The Illness Narratives* p. xvi.

⁹¹ Ibid p. 49.

relationships' recursively link the social world to patients' inner experiences of illness and identity.⁹²

Over the decades that followed, scholars such as Anne Husanker Hawkins,⁹³ Arthur W. Frank,⁹⁴ Kathryn Montgomery Hunter,⁹⁵ David E. Shuttleton⁹⁶ and Anne Harrington⁹⁷ strove, within the interdisciplinary sphere of the medical humanities, to promote the 'recognition that storytelling plays an essential and therapeutically significant part in shaping medical understanding'.⁹⁸ Such a movement, blurring the genres of literary criticism, history and anthropology with those of sociology and psychiatry, placed at the centre of research the dialogues and discourses passing between patients and practitioners, thereby provoking renewed interest in researching and reproducing the single subject case history. In her study of medical case records, Hunter asserted in 1991 that, to explore the complexities of problematic cases, the production of a narrative history was most closely suited to the representation of an individual case. Hunter wrote of modern day mental medicine that:

Biomedicine moves closer to becoming a pure science in its laboratories, but at the bedside, rightly carried out, it remains a patient-centred interpretive practice. Given the requirements of a science whose laboratory is the living person, case narrative, despite its faults, is admirably suited to the task of reporting on its investigation. In some puzzling instances (whether temporarily or for all time), narration is the best account that can be given.⁹⁹

More recently, the work of Harrington on a medical history of *Mind-Body Medicine* exemplifies the advantages of such a narrative approach when writing histories of psychiatry/mental illness. She explains: 'I focus upon stories because I believe this is the best way to carve the subject up at its joints'. In her search to unite studies of biological processes and phenomenological experiences in that, which Harrington calls, 'mind-body' medicine, she claims 'we are confronted not with an integrated vision or program but with

⁹² Ibid pp. 6, xiii. See also Morrison 'Conversing with the Psychiatrist' p. 20.

⁹³ Hawkins 'A. R. Luria and the Art of Clinical Biography'.

⁹⁴ Frank *The Wounded Storyteller*.

⁹⁵ Katherine Montgomery Hunter *Doctors' Stories, the Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991).

⁹⁶ Shuttleton *Smallpox and the Literary Imagination 1660-1820*.

⁹⁷ Anne Harrington *The Cure Within, a History of Mind-Body Medicine* (London: W.W. Norton and Company, 2008).

⁹⁸ Ibid p. 40.

⁹⁹ Hunter *Doctors' Stories* p. 106.

a patchwork of approaches and understandings that pull in many different directions'.¹⁰⁰ To take the stories of individual patients and practitioners as the starting point of historical research, and then to open out their histories into the wider social, political, philosophical and medical landscapes, was her preferred methodology, thus furthering the integration of nomothetic and idiographic epistemologies.

The work of literary critic and medical historian David Shuttleton has likewise exemplified the value of storytelling as he uses patient case records, patient poetry and correspondence dating back to the seventeenth-century to explore the role played by the 'literary imagination' in shaping cultural conceptions of disease.¹⁰¹ While such interdisciplinary endeavours filtered throughout the medical humanities, this renewed emphasis on storytelling also began to enter contemporary medical education.¹⁰² From the late-1980s, a number of undergraduate medical courses placed renewed emphasis upon the role played by storytelling in facilitating the humanistic impulses of medical care, and a reciprocal relation between contemporary medical practitioners and the hermeneutically-orientated research of literary critics and medical historians saw greater emphasis being placed on the analysis of patients' illness narratives.¹⁰³ While medical practitioners were taught to discern meaning from the 'stories that patients tell' and to learn the art of co-narrating clinical biographies or pathographies,¹⁰⁴ texts such as Sacks' *Awakenings* and Kleinman's *Illness Narratives* were introduced to undergraduate university curriculums alongside Arthur Conan Doyle's "The Doctors of Hoyland" and Anthony Trollope's *Doctor Thorne* in order that medical students learned to interpret the 'chaotic texts of medicine'.¹⁰⁵

Voices from within the asylum

From such a fertile intellectual enterprise, the works of clinical historian Allan Beveridge and scholar-archivist Michael Barfoot are notable for advancing research into the micro-

¹⁰⁰ Harrington *The Cure Within* p. 19.

¹⁰¹ Shuttleton *Smallpox and the Literary Imagination*.

¹⁰² Angela Woods 'The Limits of Narrative: Provocations for the Medical Humanities' *Medical Humanities* 37 (2011) 73-78 p. 78.

¹⁰³ Anne Husanker Hawkins and Marilyn Chandler McEntyre 'Introduction: Teaching Literature and Medicine: A Retrospective and a Rationale' in *Teaching Literature and Medicine* eds. Anne Husanker Hawkins, Marilyn Chandler McEntyre (New York: The Modern Language Association, 2000) p. 1.

¹⁰⁴ Rita Charon 'Literary Concepts for Medical Readers' in *Teaching Literature and Medicine* eds. Anne Husanker Hawkins, Marilyn Chandler McEntyre (New York: The Modern Language Association, 2000) p. 31.

¹⁰⁵ Lilian R. Furst 'Medical History and Literary Texts' in *Teaching Literature and Medicine* eds. Anne Husanker Hawkins, Marilyn Chandler McEntyre (New York: The Modern Language Association, 2000) p. 57.

histories of asylum patients through the analysis of historical patient case note records. By unearthing the letters, poetry and the case notes of two of the Royal Edinburgh Asylum's most 'remarkable' of patients, John Willis Mason and John Home, Beveridge and Barfoot illuminated the process of admission, treatment and institutionalisation in nineteenth-century Scotland. Unlike patient narratives, studied by social historians such as Peterson and Porter, that were largely autobiographical and written retrospectively, the literary outputs of the patients studied by Beveridge and Barfoot were produced within the asylum during periods of illness and during times of remission. Analysed alongside these case note records, the letters of Home and Mason revealed a rich interior history of institutional life. The records of Home, wrote Beveridge and Barfoot, enabled readers to 'share the sights, sounds and smells of institutional life' and to encounter 'the often disturbing appearance of other inmates slobbering their food or masturbating; the noise and din of the crowded galleries; and the odours of poor food and of other patients'.¹⁰⁶ In contrast, the letters, poems and case note materials of Mason cast a differing light on life in the Royal Edinburgh Asylum, disclosing a world of 'entertainments and activities; of lantern-light talks and piper-led parties ... of amateur theatricals and sports competitions'.¹⁰⁷ By compiling such differing documentary elements that formed the case note record, they traced the legal, social and clinical components that contributed to the construction of individual patient identities, and in doing so plugged the gap between social, legal and clinical histories of madness, psychiatry and the asylum institutions.

For Scull, the disadvantage of such 'meticulously detailed individual accounts' was that they ran the risk of overlooking 'larger structural and organi[s]ational imperatives'.¹⁰⁸ Lacking a longitudinal perspective, their work, while ground-breaking in its appropriation of patient narratives, arguably contributed little to histories of the development of psychiatric thought, clinical diagnoses and patient experiences beyond the time scales and spatial parameters of these singular personal histories.¹⁰⁹ It is now considered that

¹⁰⁶ Michael Barfoot and Allan W. Beveridge 'Madness at the Crossroads: John Home's letters from the Royal Edinburgh Asylum, 1886-87' *Psychological Medicine* 20 (1990) pp. 263-284.

¹⁰⁷ Michael Barfoot and Allan W. Beveridge "'Our most notable inmate": John Willis Mason at the Royal Edinburgh Asylum, 1864-1901' *History of Psychiatry* (1993) p. 199.

¹⁰⁸ Scull *The Insanity of Place/The Place of Insanity* p. 109.

¹⁰⁹ Scull argued in 2006 that as a new wave of scholars 'abandoned the language of social control' and reverted to a 'more benign' assessment of 19th century asylum institutions, a shift from global analyses of the asylum to micro histories has arguably seen scholars run the risk of overlooking the 'larger structural and organizational imperatives' which contextualized asylum histories. He states that micro histories run the risk of 'telling stories of incremental change that retreat into a sort of neo-solipsism'. See *The Insanity of Place/ The Place of Insanity* pp. 108-08. In reference to romantic and classical science, see A. R. Luria *The Making of Mind: A Personal Account of Soviet Psychology* eds. Michael Cole (Massachusetts:

Beveridge's later analysis of twentieth-century patient case note records produced by R. D. Laing offers a more nuanced intervention in both social and clinical histories of psychiatry.¹¹⁰ While concentrating primarily on the history of Laing as psychiatrist and author, the clinical orientation of this book skilfully unearths the raw case reports and clinical notes, produced by Laing during his early years of training, and charts the transformation of such case note materials to the published case histories which furnished his text *The Divided Self*.¹¹¹ In so doing, Beveridge highlights the discrepancies between Laing's unpublished accounts of individual patient cases and their revision and reconstruction within his published works. By drawing close attention to the modifications that patient case note records may undergo in their transition from the clinical encounter to the published article, Beveridge underwrote the importance of retreating back to the archives, to access the unpublished and as yet unacknowledged histories of patients and practitioners within the clinical encounter.

Case notes and case histories, methods of analysis and interpretation

Looking back to the antecedents of Beveridge's research, the work of Jonathan Andrews, conducted in 1998 on the 'Case Notes' and 'Case Histories' of Glasgow Royal Asylum in the nineteenth and early twentieth century, provides a methodological framework for the longitudinal analysis of this transitional relationship, later explored by Beveridge, between the production of an individual case note record and its publication in the form of an anonymised case history. Through examination of the changing ideological underpinnings, diagnostic criteria and formatting styles characterising Gartnaveil's case note records across the long Victorian era, Andrews demonstrated how, and more significantly why, these case note records were made available for a public readership through the publication of single case histories. The propensity of asylum Physician-Superintendents to publish case histories in the asylum's annual reports was, for example, shown by Andrews to afford the

Harvard University Press, 1979) as Luria wrote in 1979 that romantic scholars 'do not follow the path of reductionism, which is the leading philosophy of the classical group. Romantics in science want neither to split living reality into its elementary components nor to represent the wealth of life's concrete events in abstract models that lose the properties of the phenomena themselves. It is of the utmost importance to romantics to preserve the wealth of living reality, and they aspire to a science that retains this richness'. Quoted in Hawkins 'A. R. Luria' p. 6.

¹¹⁰ Daniel Burston 'Book Review: Allan Beveridge. Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R. D. Laing, 1927-1960' *Journal of the History of Behavioral Sciences* 48, 2 (2012) pp. 176-78.

¹¹¹ Beveridge *Portrait of the Psychiatrist as a Young Man* p. 195.

asylum an avenue for self-promotion; they served to ‘demonstrate the efficacy of specific treatments’, while the publication of post-mortem results conveyed information that was used to justify mortality statistics.¹¹² The case histories of patients whose treatment was successful or who showed gratitude to the asylum were seen to have been given preference within the annual reports over ones whose case notes revealing them resisting or complaining about their committal, while the case histories of interesting, even infamous patients were also noted to appear within early editions of the annual reports, sometimes for little reason other than to ‘gratify ... public curiosity’.¹¹³ As the style, contents, authorship and readership of Gartnavel’s case notes and case histories changed over the years, Andrews deduced that the construction of such documents reflected wider ‘changes and continuities in medical ideologies about insanity, social attitudes to the insane, and the nature of medical practice in asylums’.¹¹⁴ In alignment with the work of Guenter B. Risse and John Harley Warner on ‘Patient Records in Medical History’, Andrews evidenced how an array of individual histories, ‘cultural assumptions’ ‘power relationships’ and ‘bureaucratic’ measures may be encased within such records.¹¹⁵ Moreover, Andrews’ analysis of case note records demonstrates that, as networks of knowledge/power flowed between lay governors, medical staff, patients and family members, such power dynamics became embedded within corresponding case note records. Therefore, as Andrews’ analysis showed the process by which patients’ identities became constructed within the languages and the thought worlds of the psychiatric profession, he provided a blue print for scholars to further decode and contextualise case notes and case histories through the analysis of the distinct medico-socio-historical periods from which they originated.

Clinical encounters and institutional settings

Over the past decade, scholarly analysis of case note records has once again become increasingly attuned to the power relations that contextualise this essential, binary relationship between patient and practitioner in institutional confines. With regards to the British context, histories which focus upon madhouses, asylums and mental hospitals – including Gartnavel,¹¹⁶ Barony Parochial¹¹⁷ and Dundee Royal¹¹⁸ in Scotland, Ballinasloe in

¹¹² Andrews ‘Case Notes, Case Histories’ p. 271.

¹¹³ Ibid p. 268.

¹¹⁴ Ibid p. 256.

¹¹⁵ Risse and Warner ‘Reconstructing Clinical Activities’ pp. 189-90.

¹¹⁶ Andrews ‘Case Notes, Case Histories’ p. 256.

¹¹⁷ Davis *The Cruel Madness of Love*.

Ireland,¹¹⁹ North Wales and Denbigh in Wales,¹²⁰ and Bethlem,¹²¹ Brookwood, Holloway¹²² and Buckinghamshire¹²³ in England - have paid particular attention to the intersections of knowledge/power in distinct clinical encounters. For scholars such as Akihito Suzuki, the analysis of nineteenth century case note records, drawn from the archives of Bethlem Hospital, directed his attention to the tensions, previously explored by Foucault and more recently by Hunter, that exist between patient and practitioner as both engage in the act of ‘decoding and defining disease’.¹²⁴ Case note records were used by Suzuki to demonstrate that the power to define illness fluctuated between patient and practitioner across the nineteenth-century. Through the examination of Bethlem case note records dating from the 1850s onwards, he argued that the ‘case book was a far more dynamic and fluid space than Foucault’s [earlier *Madness and Civilisation*] account suggests, ripe with struggle for the status of legitimate storyteller between the patient, the doctor and family’.¹²⁵

Tensions within academia has recurrently problematised the divergent, and sometimes oppositional historical accounts of psychiatry, mental illness and asylum care that differentiate the micro-histories of Suzuki, Andrews and Beveridge from the macro-histories of Scull, Szasz and, at times, Foucault. But for scholars such as Berkenkotter, her research into the formation of case notes and case histories, as produced within madhouses, asylums and psychiatric clinics over the last 250 years, offers a heroic attempt to encompass both scales of analysis by tracing the diverse and fractured history of Anglo-American-European psychiatry. Her book, which is divided into two sections, one entitled ‘The Asylum Age’ and the other the ‘Era of Biomedicine’, is used to illustrate the major

¹¹⁸ Lorraine Walsh ‘A Class Apart? Admissions to the Dundee Royal Lunatic Asylum 1890-1910’ in *Sex and Seclusion, Class and Custody. Perspectives on Gender and Class in the History of British and Irish Psychiatry* eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodolpi, 2004).

¹¹⁹ Oonagh Walsh ‘Gender and Insanity in Nineteenth Century Ireland’ in *Sex and Seclusion, Class and Custody. Perspectives on Gender and Class in the History of British and Irish Psychiatry* eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodolpi, 2004) pp. 83-86.

¹²⁰ Pamela Michael ‘Class, Gender and Insanity in Nineteenth-Century Wales’ in *Sex and Seclusion, Class and Custody Perspectives on Gender and Class in the History of British and Irish Psychiatry* eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodolpi, 2004).

¹²¹ Akihito Suzuki ‘“Framing Psychiatric Subjectivity”, Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century’ in *Insanity, Institutions and Society 1800-1914* eds. Joseph Melling and Bill Forsythe (London: Routledge, 1999).

¹²² Anne Shepherd ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’ in *Insanity, Institutions and Society 1800-1914* eds. Joseph Melling and Bill Forsythe (London: Routledge, 1999).

¹²³ David Wright ‘Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England’ in *Sex and Seclusion, Class and Custody. Perspectives on Gender and Class in the History of British and Irish Psychiatry* eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodolpi, 2004).

¹²⁴ Suzuki ‘Framing Psychiatric Subjectivity’ p. 116.

¹²⁵ *Ibid* p. 132.

paradigm shift which she argues characterised psychiatry's transition from a humanities-based discipline to a scientifically orientated profession. Tracing the art of case note and case history taking from the early-eighteenth century case of James Tilly Matthews, through to the late-nineteenth century case note records of Edinburgh Royal Asylum, and then on to the early-twentieth century case histories of Sigmund Freud, Berkenkotter offered a longitudinal history case note record production in 'The Asylum Age'. By exploring how narrative tropes, 'lexical choices' and 'grammatical constructions' were employed by psychiatrists to integrate the narrative of the patient with that of the practitioner within case notes and case histories, Berkenkotter argued that up until the mid twentieth century the humanistic impulses of the psychiatric profession centred upon the evaluation and individualisation of single patient case histories.¹²⁶ To further question the purpose of such narrative constructs, Berkenkotter employed the analytical methods of literary, anthropological and psychological studies to evaluate sources that were highly qualitative in nature. As her text shifted to the analysis of case notes during the 'Era of Biomedicine', such analytic methodologies were replaced by a methodology that largely reflected the empirical orientation of case note records produced along biomedical lines. Following the rise of *DSM III III-R* and *IV* (Diagnostic and Statistical Manual of Mental Disorders) in North America, Berkenkotter shifted her analysis to the disappearance of the narrative case history as she statistically evaluated the emergence of published psychiatric studies that prioritised large-scale quantitative studies of patient populations.¹²⁷ By incorporating such an array of methodologies in the analysis of case notes and case histories, Berkenkotter sought to traverse previous disciplinary divides; but, as her methodological approach inevitably reflected the paradigmatic orientation of the materials under consideration, her work arguably epitomised and even enforced, rather than transcended divides within the sciences and humanities.

Diagnostic histories

It is the work of scholars such as Hilary Marland, Mark Micale, David Wright and Gayle Davis on the representation of distinct diagnostic categories in case note records that marks a more succinct use of interdisciplinary methodologies to integrate both social and clinically orientated histories of psychiatry and mental illness. For Marland, the analysis of case note records revealed how both social and psychiatric conceptions of puerperal

¹²⁶ Berkenkotter *Patient Tales* p. 153.

¹²⁷ Riki Thompson 'Review of Patient Tales: Case histories and the Uses of Narrative in Psychiatry (Carol Berkenkotter)' *A Journal of Composition Theory* 30 (2011) pp. 381-385.

insanity shaped the treatments given and aetiologies ascribed to individual patient cases within asylum institutions,¹²⁸ while for Micale, his analysis of hysteria focused upon the diagnosis as both a ‘disease and cultural metaphor’ functioning within an array of medical, scientific, cultural and political contexts.¹²⁹ Wright, who studied the case note records of over 1,700 patients admitted to Buckingham County Pauper Lunatic Asylum between 1853-1874, used both qualitative and quantitative data to explore the social context of certification, highlighting how families, workhouses, county prisons and poor law officials were instrumental in identifying and securing the admission of asylum patients. Working from a perspective that focused upon the gendering of confinement and diagnosis of asylum patients, Wright concluded (in agreement with Scull) that, despite earlier gender historians such as Phyllis Chesler and Showalter claiming a ‘misogynist’ taxonomy of psychiatric classification leading to women being disproportionately confined in Victorian asylums, statistical analysis of admission documentation refuted such claims.¹³⁰ Wright insisted that, while previous studies have focused upon histories of diagnostic categories that arguably pathologised culturally unacceptable behaviours of women, such as hysteria, ovarian madness and climacteric insanity, these diagnoses comprised a relatively small number of predominantly upper-middle class female cases and are therefore unrepresentative of asylum populations as a whole.¹³¹ The value of conducting both qualitative and quantitative research across the entirety of the asylum population was therefore emphasised by Wright as he explored how alternative factors, such as class, family dynamics, economic circumstances and the ‘epidemiological reality of many mental disorders’, shaped the diagnosis and certification of women in Victorian asylums.¹³²

Most significantly for the orientation of my own research is the work of Davis on the case note records of Gartnavel Royal, Royal Edinburgh, Barony Parochial and Midlothian and Peebles Asylums from the 1880s to the 1930s. Davis confronted these records from a truly multidisciplinary approach, charting the reciprocal relations between clinical and social conceptualisations of patient identities and diagnostic categories. By charting the diagnostic history of syphilis, Davis enjoined an interior history of the clinical encounter

¹²⁸ Hilary Marland ‘“Destined to a Perfect Recovery”’ the Confinement of Puerperal Insanity in the Nineteenth Century’ in *Insanity, Institutions and Society 1800-1914* eds. Joseph Melling and Bill Forsythe (London: Routledge, 1999) p. 150.

¹²⁹ Mark Micale *Approaching Hysteria: Disease and its Interpretations* (Princeton: Princeton University Press, 1995).

¹³⁰ Wright ‘Delusions of Gender?’ p. 170.

¹³¹ *Ibid* pp. 170-71.

¹³² *Ibid* p. 169.

through the examination of case note records, to an analysis of the wider social and professional contexts which infused psychiatric practice, and therefore, as I go on to discuss, her work provides me with a methodological blueprint for further study into the use and interpretation of case note records. For while she addressed the history of a somatic disorder and its treatment across four distinct Scottish asylums, the analysis of case note records allowed her to trace ‘both the clinical and cultural profile of ... neurosyphilitic disorders’ and their convergence within clinical encounters.¹³³

Looking to the scale of Davis’ research, we see that on a localised level, disease and its treatments were envisaged on a micro-scale of analysis. By situating her study in institutional confines, Davis envisaged the active, day-to-day processes, by which both patients and practitioners gave meaning to disease. On the one hand, Davis captured the relations of power and knowledge that bound patients’ minds and bodies to the therapeutic practices of ‘alienists’ and psychiatrists. On the other, she questioned how issues of gender, generation, class and race impacted upon the course of treatment and prognosis.¹³⁴ Moreover, far from Davis’ work being confined to a remote regional study, these distinct case note records were contextualised against the wider cultural, scientific and regional backdrop of Britain during this period.¹³⁵ By charting wider developments in laboratory research and chemical analysis across Europe and North America, alongside shifting medico-cultural conceptions of degeneracy and civilisation,¹³⁶ Davis’ work ranged from intimate encounters with individual patient cases and institutional practices, to more far-reaching analyses of the impact made by scientific technologies, moral philosophies and societal fears upon medical-social conceptions of syphilis.¹³⁷

Affect and environment

It is finally to the geographically-orientated works of social scientists, literary critics, cultural historians and human geographers who study the phenomenological worlds of asylum patients and mental health sufferers, that this historiography turns before drawing to a close. Burgeoning interest, shown by such researchers, in the ‘space reserved for

¹³³ Davis *The Cruel Madness of Love* p. 30.

¹³⁴ Ibid pp. 180-181.

¹³⁵ Ibid. Chapter 6 on ‘Aetiology and Social Epidemiology’ demonstrates how Victorian notions of degeneration drew heavily upon both social and medical concepts of morality and disease, and it was therefore this ‘medico-scientific’ framework that was challenged by later scientific developments such as the Wasserman test. pp. 199-231.

¹³⁶ Ibid p. 199.

¹³⁷ Ibid pp. 199-231.

insanity,¹³⁸ has increasingly led to studies of madness/mental illness being referenced to distinct geographical and institutional settings. Case note records and other archival materials have played a significant role in shaping these studies, as research specifically questions how interior and exterior asylum spaces affect patients' phenomenological experiences of illness and identity.

For instance, cultural historian George Rousseau writes 'the medical world' is composed not only of medical theory and individual actors, but is set within a landscape populated by 'instruments and machines, aesthetics and architecture'. While the 'interior spaces of operating pavilions, wards, [and] private rooms' are considered alongside 'the colors and textures of the exteriors and interiors', he argued researchers must explore *how* the narratives of patients and practitioners were framed, informed, reflected and shaped by such distinct clinical confines.¹³⁹ The work of archaeologist Susan Piddock on the architectural history of Australian asylums likewise showed that such interior spaces can be explored in relation to the affects evoked among their inhabitants. Maps and architectural plans, stated Piddock, offer 'static representations of moments in time when the asylum was planned and built', but, to investigate the use of these buildings, the researcher must extend their research to the moral, medical and cultural ideologies infusing architectural designs.¹⁴⁰

Historian Catherine Coleborne's research upon patient case note records and patient correspondence exemplified the application of a geographically nuanced approach to the examination of case note materials. Through the examination of four Colonial Australian and New Zealand hospitals for the insane, dating back to the 1880s through to the 1910s, Coleborne examined how a historical-geography of the emotions may be drawn from institutional records. By paying close attention to the bonds of emotion articulated between asylum patients, their relations and asylum Physician-Superintendents, Coleborne questioned whether 'past emotional cultures' might be evidenced through 'the asylum and its sources'.¹⁴¹ The performative nature of emotional expression within clinical confines was most poignantly trawled from patients' personal correspondence by Coleborne,

¹³⁸ Philo *A Geographical History*, this quote, which paraphrases Foucault, is taken from the title page.

¹³⁹ Rousseau *Enlightenment Borders* pp. 9-10.

¹⁴⁰ Susan Piddock *A Space of Their Own: The Archaeology of Nineteenth Century Lunatic Asylums in Britain, South Australia and Tasmania* (New York: Springer, 2007) pp. 40, 97, 101, 216-219.

¹⁴¹ Catherine Coleborne 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880-1910' *Social History of Medicine* 19 (2006) 3 425-442 p. 427.

suggesting that a number of patients ‘knew how to ‘perform’’ both their symptoms and their recoveries within distinct temporal, spatial and inter-personal parameters. Letters written by family members to asylum Physician-Superintendents were likewise considered to provide a contemporary outlet for the expression of fears, frustrations, longings and miseries, which may otherwise have remained stifled outside of the medical sphere.¹⁴²

Human geographers, working from an array of interdisciplinary perspectives, have likewise adopted and adapted the literatures of ‘cognate studies’ such as sociology, cultural studies and anthropology in an array of historical, philosophical and spatial frameworks, to explore histories of psychiatry/mental illness. Spaces traditionally reserved for ‘insanity’ such as madhouses and asylums have been explored at both macro and micro scales of analysis, as scholars have endeavoured to penetrate some of the most intimately felt spaces¹⁴³ and ‘imaginative geographies’¹⁴⁴ possessed and experienced by those considered mentally ill.¹⁴⁵ For scholars such as Chris Philo, his work, ‘scaling’ distinct locational geographies of mental health provision, has further alerted scholars to the personal relations that bind individual experiences of mental illness to differing historical-geographical spaces. In research which took nineteenth-century case note records as a source of historical investigation, Philo pushed beyond the medical/theoretical frameworks contemporarily imposed upon patient cases, enjoining the analysis of medical envisionings of time, space, memory and mind to that of patients’ interior, imaginatively populated mental landscapes.¹⁴⁶ Case notes and patient art works, wrote Philo, prompted him to ‘contemplate the alternative, more unsettling historical geographies of madness as dimensions of [a] lived, felt, suffered, emotional reality’.¹⁴⁷

¹⁴² Ibid p. 438.

¹⁴³ Chris Philo ‘Scaling the Asylum. Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)’ in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* eds. Leslie Elizabeth Topp, James E Moran and Jonathan Andrews (New York: Routledge, 2007) p. 103.

¹⁴⁴ Chris Philo ‘Madness, Memory, Time, and Space: the Eminent Psychological Physician and the Unnamed Artist – Patient’ *Environment and Planning D: Society and Space* (2006) 24 p. 903.

¹⁴⁵ Hester Parr and Ruth Butler ‘New Geographies of Illness, Impairment and Disability’ in *Mind and Body Spaces, Geographies of Illness Impairment and Disability* eds. Ruth Butler and Hester Parr (London: Routledge, 1999).

¹⁴⁶ Philo ‘Madness, Memory, Time and Space’ p. 899.

¹⁴⁷ Among his published works, Philo’s exploration of the published case history and unpublished case note records of William James Blacklock is particularly relevant to this thesis. Blacklock, a patient admitted to the Crichton Royal Institute in the mid-nineteenth century, suffered from syphilitic infection, and during his stay as a mental patient in the Crichton Royal he created pen and ink sketches, depicting an array of alien, seemingly imaginary landscapes. These landscape sketches were interpreted by Thomas Laycock, an eminent nineteenth-century Edinburgh psychiatrist and evolutionary theorist, as evidencing the patient’s ‘reversion’ to a ‘substrata’ of mental functioning that first existed in the patient’s childhood, itself rooted in ancestral, uncultured modes of behaviour. With this interpretation in mind, Philo’s paper traced the intellectual, social and cultural spaces in which Laycock’s ideas took form. Focusing in

The work of Philo dovetails with the research of Cheryl McGeachan, who charted the approach taken by R. D. Laing as he sought to enter into the delusional worlds and psychotic spaces of asylum patients. McGeachan stressed that the ‘space of treatment itself’ played an active role in shaping ‘Laing’s engagements with his psychiatric patients’. By ‘opening up, and being attentive to these differing spaces and places’ in which therapies and treatments were conducted, McGeachan traced the process by which Laing began to resist the routine practices occurring within the enclosures of psychiatric institutions.¹⁴⁸ By taking a geographical approach to the biography of Laing, McGeachan’s work resisted applying a linear narrative framework to Laing’s life, but rather opened up avenues of enquiry that are spatialised, and which situate pivotal aspects of Laing’s career and intellectual development within discrete geographical locations.

As scholars have endeavoured to penetrate those interior spaces in which histories of psychiatry/mental illness were so often situated, burgeoning interest in geographies of ill-health, affect and emotion have inspired human geographers to think and feel their way around spaces reserved for the mentally ill.¹⁴⁹ In 2007 a collection of works on the theme of

particular upon the contemporary proliferation of evolutionary theories, this ideological climate, argued Philo, gave shape to Laycock’s published case and his theory of ‘reversion’. Yet while Philo was interested in a history of medical ideas, he was also interested in the sketches themselves. By searching out Blacklock’s original pen and ink drawings, held within the unpublished case note records of this case, Philo made public a collection of patient art works - the subjects of which blurred the boundaries between human figures and buildings, between gothic architecture and abstract or emaciated bodies. Ibid p. 913.

¹⁴⁸ Cheryl McGeachan ‘Needles, Picks and an Intern Named Laing: Exploring the Psychiatric Spaces of Army Life’ *Journal of Historical Geography* 14 (2013) p. 68. For instance, while Laing was conscripted in 1951, he found himself working at the Royal Victoria Military Hospital in Netley, Southampton, and it was this passage of transition, from medical intern to army conscript, which McGeachan spotlighted as a pivotal point in the young psychiatrist’s career. Her description of the outer architectural splendour of Netley contrasted sharply with her portrayal of the inner ‘prison’ of iron gates and padded cells, sharpening the transition made by Laing to an interior world ‘invisible to the outsider’s gaze’. The interior - furnished with padded cells - was explored as the physical extension of military discipline, with the insulin coma ward and the spaces reserved for electric shock treatment reflecting the biological orientation of military mental medicine in this period. The psychiatric profession’s use of distinct physical wards for specialised biological treatments was treated by McGeachan as a particular ordering of space that created deeply evocative, indeed disturbing environments, ones unavoidably inflecting relations between patient and practitioner. As Laing crossed the threshold of such wards, his desire, as McGeachan convincingly demonstrates, to circumvent the boundaries that often separated patient from practitioners provoked some of Laing’s most influential and radical approaches to the treatment of the mentally ill. Ibid pp. 73-76.

¹⁴⁹ The ‘turn to affect’, which was espoused and critiqued by scholars such as Liz Bondi, Joyce Davidson, Mick Smith, J. D. Dewsbury, Hester Parr, Felicity Callard and Ruth Leys, has further enabled historical geographers of psychiatry/mental illness to explore the relations which bind bodies, emotions, thoughts, identities and environments; producing research which spans vast temporal and spatial arenas. See Liz Bondi, Joyce Davidson and Mick Smith ‘Introduction; Geographies “Emotional Turn”’ in *Emotional Geographies* eds. Joyce Davidson, Liz Bondi, Mick Smith, (Hampshire: Ashgate Publishing Ltd, 2007)

Madness, Architecture and the Built Environment saw the use of mental hospital case notes in research dominated by themes of space, place identity and emotion. In Davies' contribution to this collection, already mentioned, she used case notes from the 1950-80s alongside oral histories (conducted between herself and hospital patients) to enquire into patients' differing uses, understandings and engagements with hospital spaces. The effects/affects that physical fixtures and fittings (such as the smell of paint or the spatial demarcation of wards) have upon the structuring and telling of patient narratives were analysed by Davies, alongside her assessment of patients' engagements with the less tangible, social elements of buildings, associated with the formation of group identities or the presence of 'atmosphere'.¹⁵⁰ While this chapter accomplished many things, most notably in drawing upon patient narratives, Davies' longitudinal study was significant for its ability to demonstrate the potential for historical-geographical studies to reflect, sensitively and subjectively, upon patients' responses to the process of deinstitutionalisation. Linking with my own work, it feeds contemporary debate with a historical corpus of knowledge, garnered from the patient perspective.

For instance, Davies argued that before the large-scale closure of mental hospitals in the 1980s and 90s, patients' experiences of institutional care were, in many ways, collectively engendered. Through the analysis of case notes and oral histories, Davies demonstrated that, as patients were grouped within distinct hospital wards, affording differing privileges and treatments, they often came to structure their identities and stories around the spaces collectively occupied. In the earliest period of this study, patients' use of 'inside/outside metaphors' was seen by Davies to evidence a stark contrast between hospital and community living, but these distinction become less marked in interviews and case note records dating to the latter decades of the twentieth-century. With increased 'pressure' being placed upon patients to 'leave hospital', patient narratives reflected the increasing 'fragmentation' and individualisation of patient spaces. While neither condemning, nor actively supporting the deinstitutionalisation movement, Davies underlined the

p.1. See also Parr and Butler 'New Geographies of Illness, Impairment and Disability'. Ruth Leys 'The Turn to Affect: A Critique' *Critical Inquiry* 37, 3 (2011) 434-472, and Constantina Papoulias and Felicity Callard 'Biology's Gift: Interrogating the Turn to Affect' *Body and Society* 16, 1 (2010) 29-56.

¹⁵⁰ Kerry Davies "'A Small Corner that's for Myself" Space, Place, and Patients' Experiences of Mental Health Care, 1948-98' in *Madness, Architecture and the Built Environment* eds. Leslie Topp, James E. Moran and Jonathan Andrews (New York: Routledge, 2007) p. 306. - "'Silent and Censured Travellers"'? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948' *Social History of Medicine* 14 (2001) 267-92.

significance of patient narratives to our understanding of this monumental shift in mental health policy:

[O]ur perceptions and interpretations of the spatial history of mental health and illness need to be informed, not only by the intentions of psychiatrists, planners, and architects in the creation of institutional spaces ... but by the ways in which such spaces have been used, experienced, negotiated, accepted and interpreted by patients.¹⁵¹

Concluding with the ideological framework to emerge from the historiography

In lieu of such a stimulating, yet diverse and fractured historiography, the medico-cultural dichotomy, which Mark Micale once referred to as a ‘stubborn and unproductive’ divide, is progressively being revised, as histories of psychiatry, mental illness and mental institutions are becoming highly interdisciplinary subjects of enquiry.¹⁵² The need of the ‘historian of psychiatry’ to ‘have a broad base in social, cultural, political, religious and intellectual history’ is being rigorously affirmed¹⁵³, but until recently, the ability of scholars to produce interdisciplinary studies informed by nineteenth and early twentieth-century case note records has remained problematic. This difficulty is arguably due to the contents of source materials themselves, for, as the somaticist ideologies of late-Victorian psychiatry spilled over into the early decades of the twentieth century, few asylum practitioners saw value in recording patient testimony. Moreover, the first person dialogues of psychiatrists, as Porter remarked, are barely heard, ‘mask[ed]’ behind ‘clinical case notes’.¹⁵⁴ Andrews informs us that the case note records of Gartnavel itself evidence the advancement of materialist medical rhetoric from the 1870s onwards, coinciding with the disappearance of patient testimony from its pages.¹⁵⁵

At Gartnavel, however, the near unique blend of psychobiological, psychoanalytic and Kraepelinian psychiatry was, by the 1920s, overhauling, indeed forcefully breaking, decades of silence. Patient stories, testimonies, utterances and writings came to populate the pages of case note records, alongside, and in dialogue with, those of Gartnavel’s medical officers. Moving away from psychiatry’s former emphasis on the description of

¹⁵¹ Ibid p. 317.

¹⁵² Micale *Approaching Hysteria: Disease and its Interpretations* p. 132.

¹⁵³ Ibid p. 6.

¹⁵⁴ Porter *Mind Forg’d Manacles* p. 275.

¹⁵⁵ Andrews ‘Case Notes, Case Histories’ p. 278.

symptoms, classification and brain pathology and towards studies of the individual personality, set within, and reacting to, their environment, it is from the resulting life histories of Gartnavel's patients that a 'history from below' begins to emerge of the dynamic clinical encounter. These archival remnants reveal a time and place in the history of Western psychiatry that took seriously the roles of both psychiatrist and patient in co-authoring the 'illness narrative', evidence of which now exists upon the pages of Gartnavel's dynamic case note records.

Because of the near unique contents of the dynamic case note record, these sources enable my own methodological approach to take advantage of interdisciplinary research models emerging within current academia. Crossing disciplinary divides, the contents of such sources necessitate I possess an in-depth awareness of the social and cultural contexts in which these records were embedded, alongside a rigorous working knowledge of the content, form and development of the psychiatric knowledges and clinical practices that preserved, framed and gave distinct meanings to the voices of patients and psychiatrists. Moreover, I must be attentive to the personal experiences, actions and agencies of individual historical actors, while never losing sight of the wider structural, organisational and spatial parameters which contextualised nineteenth-century asylums and the emergent mental hospitals of the twentieth century. Crucially I must be aware of my own politicised judgements and motivations in pursuing this project, while recognising the intended, as well as the possible unintended, consequences of voicing such a history.

Of course, while Gartnavel's case note records enable such an approach, I recognise these sources are in no way an unmediated window into clinical encounters and psychiatric practices. Working with clinical records, letters and medical textbooks, these 'residues' of human history communicate particular, individually and socially mediated constructions of reality. Like any historian, I deal with symbolically mediated aspects of human history as opposed to the immediate observation of biophysical, cognitive and affective happenings of human action. Being thus far removed from the events under study I am aware that my own selection, ordering and interpreting of source materials, imposes further layers of meaning.¹⁵⁶ Therefore, in light of the above historiography, I conclude by reflecting critically upon my own theoretical approaches to the study of the dynamic case note record.

¹⁵⁶ Ibid p. 8.

Overview of my theoretical approach

Language and textual interpretation

Analysis of case note records has, over the years, been shown by scholars such as Risse and Warner, Ingram, Andrews, Davis, Berkenkotter and Scull to demand particular interpretative strategies. My methodological approach to the study of the case note record is laid down in detail in chapter three, but to briefly summarise my position I, in alignment with Ingram and Andrews, regard these sources first and foremost as textual constructs. Considered as artefacts of a dialogue, encased within a system of writing, I take heed of the earlier works of Lacan, Derrida and Foucault and engage a critical hermeneutics of the case note record. As Ingram states: '[i]t is at the point of expression that the historian is entitled to take an interest', and therefore I explore the expression of thought, feeling and experience from the point that it was made knowable through linguistic and textual interpretation.¹⁵⁷ As Philo and McGeachan contend, the 'crucial element in most ... [therapeutic] encounters is the relationship between therapist [and] client/patient'. '[I]t is in this realm where words, and the work they do in the world, become of paramount importance'.¹⁵⁸ These words, once spoken in clinical spaces, were mediated by psychiatrists, clinical clerks and stenographers; contextualised and compartmentalised within the case note record, before being interpreted within psychiatric frameworks of thought, and therefore I question just how these examinatory processes and interpersonal relations between patient and psychiatrist left their mark upon the handwritten, or typescript page. Crossing the boundaries between textual interpretation and the analysis of semiotics in a broader sense, I question how core metaphors and rhetorical devices, used by patients and psychiatrists, alongside medical and cultural models of illness and identity, were used to give meaning to the illness narrative. By excavating the dialogues that passed between patients and medical officers within clinical encounters, I examine the power of words to make real the efficacy of medical concepts and the constitution of power relations. Moreover, I explore how cultural references and symbolic inferences of illness and selfhood seep into patient/psychiatrist dialogues, questioning in turn the effect that symbolism, metaphor and metonym had upon the creation of individual and group identities within clinical encounters.

¹⁵⁷ Ingram *The Madhouse of Language* p. 8.

¹⁵⁸ Philo and McGeachan 'Words' p. 17.

Madness/mental illness

‘Does the history of psychiatry have an object?’ asked Borch-Jacobsen in 2009, and ‘if so, what object?’ Madness/mental illness, he postulated, has often been argued as the unifying, central thematic. But what has proved so divisive amongst scholars and practicing psychiatrists is that while the study of mental illness is, to varying degrees, the study of biologically determined illnesses, it is likewise the study of a *subject* which is ‘varying and fluctuating in character’, precisely because it reacts to the ‘vicissitudes of history and the influences of the environment’. Mental illness, he goes on to argue, ‘however real it may be’ in biological terms, ‘does not exist *apart* [my emphasis] from the various discourses and practices that *make* it exist’.¹⁵⁹

With the study of mental illness considered inseparable from the study of the temporal, biological, spatial and discursive contexts in which it existed, I find myself grappling with a particularly perplexing subject. ‘Language’ for Foucault, may have been recognised as ‘the first and last structure of madness’,¹⁶⁰ however, when reflecting upon the wider historiographical tensions that have proved so divisive in histories of psychiatry, madness and asylum care, it is essential to grasp the concept of mental illness, which has, over the years, undergone numerous conceptual shifts, and recognise the extreme complexity and multiplicity of perspectives that must be taken into account when exploring its history. As Berkenkotter stated, when writing upon the subject of ‘madness’ one is always in the midst of an intractable dichotomy that continues to underlie histories of psychiatry, mental illness and asylum care, for:

Within psychiatry’s domain human beings are both organisms and agents, objects and subjects, existing in a world of meanings as well as the world of matter. This is the reason that the methods of both the human sciences and the natural sciences are essential to psychiatric practice.¹⁶¹

Cultural historian Charles Rosenberg’s concept of ‘disease as frame’ therefore underpins my approach to the analysis of mental illness. Rosenberg charts the construction of specific disease entities from our understanding of their biological dimensions to the articulation and configuration of diagnostic categories during distinct historical periods. In doing so, he

¹⁵⁹ Borch-Jacobsen *Making Minds and Madness* pp. 1-5.

¹⁶⁰ Michel Foucault quoted in Ingram *The Madhouse of Language* p. 8.

¹⁶¹ Berkenkotter *Patient Tales* p. 5.

highlights how a ‘complex network of social negotiations’ shaped the ‘total experience of sickness’.¹⁶² The boundaries between social, cultural, biological, temporal and spatial components of disease are envisaged as ‘porous’, constantly being shaped by processes of perception, articulation, negotiation and construction between laypersons and physicians, and I likewise engage with such an epistemology: one that envisages ‘mental illness’ to exist in a polymorphous state, being both biologically dependent and culturally constructed. In alignment with Kleinman, the use of the term mental illness refers to something ‘fundamentally different from ... disease’. While the ‘hard and sobering factuality of the body’ is recognised as an integral component to the aetiology and corporeal reality of experiencing illness,¹⁶³ I endeavour to recover how patients, practitioners, family members and wider member of society ‘perceive, live with’ represent and ‘respond’ to symptoms of illness.¹⁶⁴

Affective spaces and institutional places

For scholars such as Angela Woods, the limitations of narrative to represent, and through which to understand experiences of health and illness, means that we must also pay attention to what is ‘unfinished, incomplete, and tentative – the myriad forms of non-narrative communication including all the dimensions of embodied interaction’.¹⁶⁵ By taking a human-geographical approach, I begin to unearth those past physical places, and interpersonal spaces, which once contextualised case note record production.¹⁶⁶ Taking inspiration from Porter, who argued that ‘the history of mad people’s writing is a crescendo of reaction to ... the dominating presence of the asylum’, this overarching contextual edifice of bricks and mortar is ever present within this thesis.¹⁶⁷ For, as the disciplinary regimes, physical confines and penetrating gaze of the medical profession suffused the hospital environment, such conditions integrally shaped the discourses passing between patient and practitioner. But in contradistinction to the more politically charged and condemnatory works of the anti-psychiatry and social control movements of the 1960s and 1970s, this thesis demonstrates that as patients and psychiatrists were, to differing degrees, physically bound to the dormitories, day rooms and grounds of Gartnavel, their narratives may not only reveal a history of suffering, control, confinement and

¹⁶² Rosenberg ‘Introduction Framing Disease’ pp. xvi-xviii.

¹⁶³ Hawkins and McEntyre ‘Introduction: Teaching Literature and Medicine’ p. 2.

¹⁶⁴ Kleinman *The Illness Narratives* p. 3.

¹⁶⁵ Woods ‘The Limits of Narrative: Provocations for the Medical Humanities’ p. 76

¹⁶⁶ Rousseau *Enlightenment Borders* p. 9.

¹⁶⁷ Porter *Mind Forg’d Manacles* p. 273.

disempowerment, but, as Tomes suggests, also one of care and companionship.¹⁶⁸ In alignment with recent scholarly interest in the ‘turn to affect’, I content that, as histories of emotion, imagination, experience and identity may be excavated from Gartnavel’s case note records, an interior history of the hospital may be revealed, one that blends notions of self and bodily experience with the distinct physical environments of Gartnavel.¹⁶⁹

Scaling the walls of the asylum, a narrative approach

Taking heed of Scull, the in-depth, micro-scale analysis necessitated by this approach is complemented by research that transgresses the boundaries of the mental hospital and looks to the wider social, geographical and political contexts in which case note records were produced. In accordance with the research of Davies on the subject of patient testimony, I consider how the dialogues that passed between patient and practitioner may pull their readers in many different directions.¹⁷⁰ Lurching backwards and forwards in time, space, memory and imagination, patient case notes may be probed to reveal how a patchwork of cultural histories, subjective stories, psychiatric practices and phenomenological experiences collided within the clinical encounter.

By using a narrative approach, which endeavours to bridge the paradigmatic gap between the social sciences and the humanities, and which draws together macro and micro scale of perspective, storytelling acts as the ‘lynch pin’ around which I bind this thesis’ diverse methodological approaches and historical subjects. Beginning, in the following chapter, with a biographical account of Henderson’s early career, a narrative framework enables me to explore how Henderson’s experiences were shaped by, and went on to influence, a wider history of clinical practices and psychiatric knowledges. As Edwin R. Wallace advises, I use correspondence records as a medium through which to ‘think and feel’ my way into Henderson’s ‘scientific temperament, personal characteristics, cultural ambience, intellectual prehistory, theoretical biases ... [and] professional experience’. In doing so, I endeavour to unite his biographical history with a sociocultural critique of his clinical writings and published works.¹⁷¹ Taking heed of Beveridge’s analysis of Laing and the factual discrepancies that emerged between the published record of his career and that which was revealed in the unpublished case note records, I use case note records to craft a ‘history from below’ of clinical practices and patient/psychiatrist relations. Moreover, as I

¹⁶⁸ Tomes ‘Feminist Histories of Psychiatry’ p. 359.

¹⁶⁹ Bondi, Davidson and Smith ‘Introduction; Geographies ‘Emotional Turn’ p. 1.

¹⁷⁰ Davies “‘Silent and Censured Travellers’?” p. 274.

¹⁷¹ Wallace ‘Historiography, Philosophy and Methodology of History’ p. 12.

sift through archival remnants of patient testimony, (preserved within case note records), I am inspired by scholars such as Porter, Ingram, Showalter and Davies to look past the thematic constraints of histories focusing solely upon psychiatric theories and clinical practices, and to expose to critical scrutiny those other discourses, beliefs, experiences, objects and environments, that shaped patients' understanding and experience of mental illness. By intertwining a biography of Henderson and the trans-Atlantic movement of psychobiology, with the exploration of patient and practitioner testimony and its inclusion within case note records, I investigate how these differing worlds, being that of the patient and that of the psychiatrist, collide within clinical encounters.

Paradox of the object/subject of study

When reflecting on the above historiography, the somewhat dichotomous identity of the patient - being both object and subject within the case note record - is a continuous theme that runs throughout my research. Inspired by scholars such as Foucault, Berkenkotter and Leys,¹⁷² who point out this underlying tension within the history of psychiatry, I enquire how dynamic psychiatrists such as Henderson, who foremostly defined mental illness as an 'individual affair', negotiated the formation of patients as both individuals, and as members of diagnostic groupings, within the construction of case note records.¹⁷³ In doing so, my work feeds into current debate, which challenges the dominance of the biomedical model within contemporary psychiatric practice. For, while scholars - writing from within and outwith the psychiatric profession - are currently challenging the dominance of biomedicine, scholars such as D. B. Double and David Pilgrim promote the use of a biopsychosocial model of medicine, the antecedents of which lie with Meyer's psychobiology.¹⁷⁴ Although I write from the perspective of a historian rather than a psychiatrist, I myself am supporting a return to more integrated, interdisciplinary studies of psychiatry and mental illness. While I look to histories of social and environmental, as well as biomedical components of illness recorded within Gartnavel's case note records and corresponding archival materials, I utilise a philosophical outlook and discourse paradigm that was in many ways promoted by Meyer, which is now being revisited and revised by members of the psychiatric profession.

¹⁷² Foucault *Discipline and Punish* p. 189-191. Berkenkotter *Patient Tales* pp. 4-5. Leys 'Types of One'.

¹⁷³ Henderson and Gillespie *Text-Book of Psychiatry* (1927) p. viii.

¹⁷⁴ David Pilgrim, 'The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future?' *Journal of Mental Health* 11 (2002): 585-94. See also Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine'.

Figure 2. Top photograph of Craig House c. 1900 P/PL7/B/C/010, bottom photograph of West House c. early 20th century (no identifier), portrait of Thomas Clouston P/PLI/NI/023, courtesy of Lothian Health Services Archive, Edinburgh University Library.

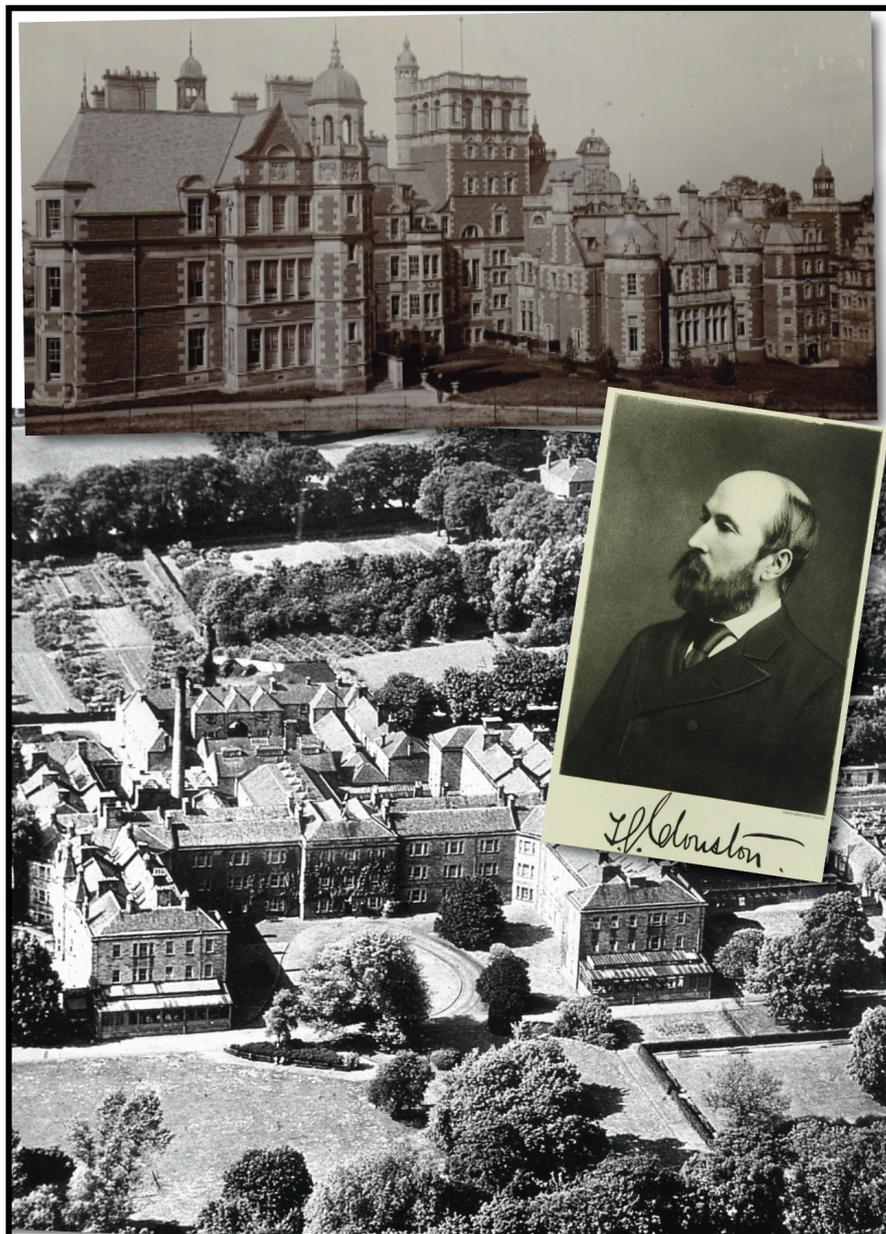


Figure 3. Portrait of Charles Macfie Campbell PH3/11 c. 1930s image courtesy of Lothian Health Services Archive, Edinburgh University Library, Correspondence between Meyer and Campbell folder I/595/1 and I/595/3, courtesy of Alan Mason Chesney Medical Archives

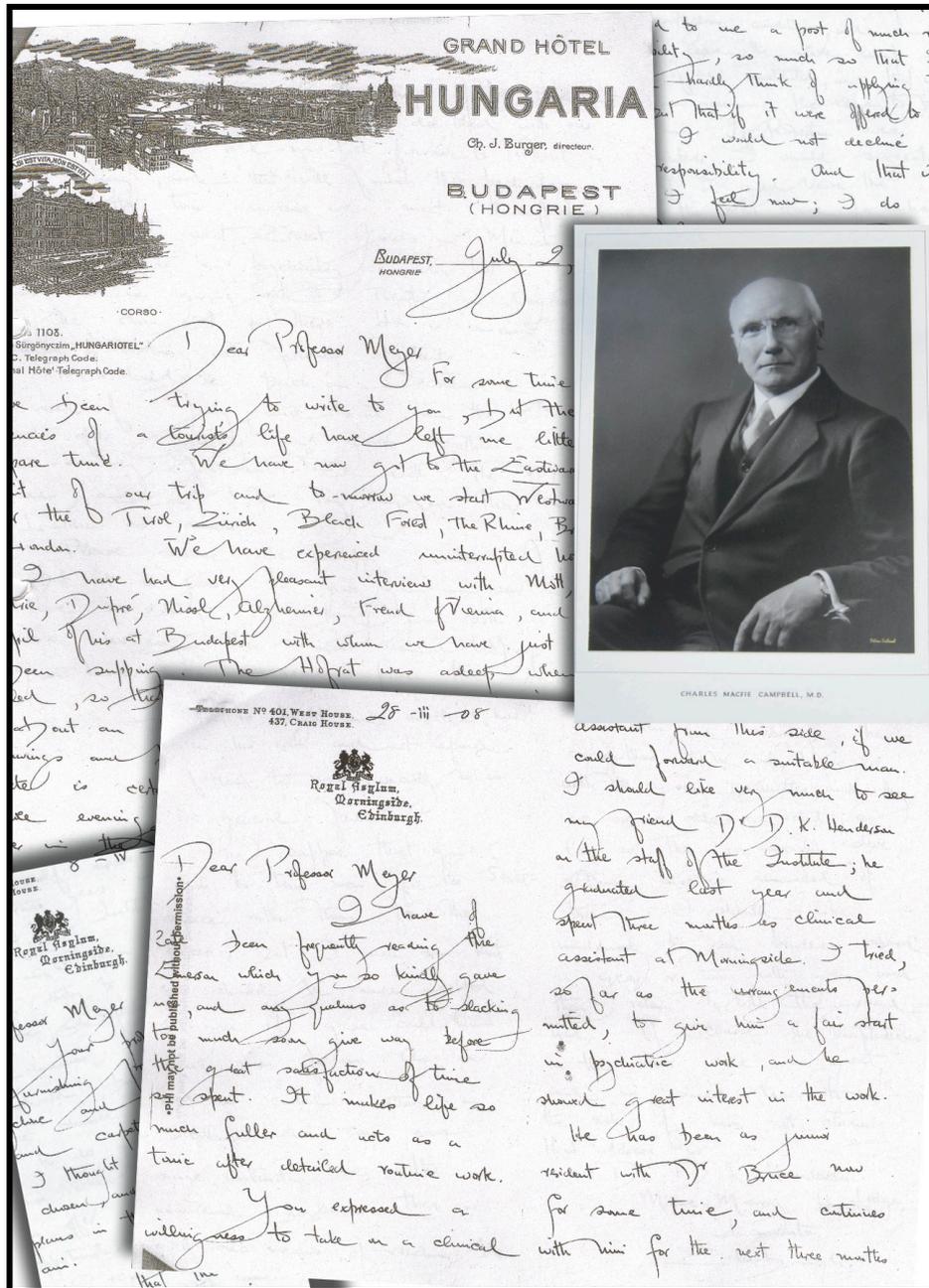


Figure 4. Thistle embellished items, place cards, poems and transcript relating to meal dedicated to Henderson at the Pathological Laboratory, New York, in Henderson correspondence folder I/1659, courtesy the Alan Mason Chesney Medical Archives. Photographs of the Laboratory's staff c. 1910-1911 Box 4 OF 7, Photograph Collection, courtesy Alan Mason Chesney Medical Archives.



In a letter written by Henderson to Eunice Winters, editor of the *Adolf Meyer Collected Papers*, Henderson wrote that the group photograph (included in the center of fig 4 above) dated back to 1910-11 and was taken on Wards Island, New York, on the occasion of a post-graduate course. 'Front Row: D.C.B. Dunlop, Dr William MaBon (Superintendent of the Manhattan State Hospital and my father-in-law) August Hoch, Adolf Meyer, C.M. Campbell. Back Row: (from left to right) Unknown, Unknou, Ross Chapman (he became med. Super. Of ... Enoch Pratt Hospital, Baltimore) Taddiken (he became Med. Super. Ogdensburg State Hospital) D.K.H., Unknown, C. I. Lambert (he stands behind Hoch); Ralph Folsom. Charles Rickshen, Unknown, Ross, Unknown, W.W. Wright'. Box 4 of 7, Photograph Collection, courtesy of the Alan Mason Chesney Medical Archives.

CHAPTER TWO

HENDERSON, MEYER AND A DEVELOPMENTAL HISTORY OF A DYNAMIC APPROACH

David Kennedy Henderson (1884-1965), ‘widely known as D.K.’ to his contemporaries, was born to John and Agnes Henderson in the Scottish borders in 1884. The sixth son of a solicitor, he attended school in Dumfries and then at the Royal High School in Edinburgh, before graduating from Edinburgh University in 1907 with a Bachelor in Medicine.¹ From then on he pursued a career in psychiatry; one that began with the somatic-pathological perspective of British psychiatry, and which soon broadened out to incorporate Kraepelinian classificatory teachings and the dynamic theories and practices of Adolf Meyer.² Having trained between 1908 and 1919 in medical institutions and centres of learning such as the Royal Edinburgh Asylum, the Pathological Laboratories of the New State Hospitals, the Nussbaumstrasse Clinic in Munich, the Henry Phipps Psychiatric Clinic in Baltimore, and the Lord Derby War Hospital in Lancashire, Henderson returned to Scotland in 1919 and was promoted to Physician-Superintendent of Gartnavel Mental Hospital in 1921. It was here, writes his colleague Donald Ewan Cameron, that Henderson pioneered the cause of dynamic psychiatry within the British psychiatric profession:

Long before any other centre in Great Britain began to stir in response to the remarkable things which were being done on the North American continent, he began to send his young men to train with Adolf Meyer ...³

In 1931 Henderson left Gartnavel to take up the prestigious post of Physician-Superintendent of the Royal Edinburgh Hospital for Nervous and Mental Diseases (formerly the Edinburgh Royal Asylum). At the height of his career, Henderson held the position of Physician-Superintendent of the Royal Edinburgh alongside the Professorship of Psychiatry at Edinburgh University. He was the principal author of one of the most successful psychiatric text-books of the twentieth-century, a pioneering advocate of the use of occupational therapies for the mentally ill, and a keen promoter of social services for the

¹ D. Ewen Cameron ‘In Memorium, David Kennedy Henderson (1884-1965)’ *American Journal of Psychiatry* 122 (1965) 467-469. See also Douglas Haldane ‘Vignette: a Doyen of ‘Psychological Medicine’ Sir David Henderson’ [www.mdus.com/media/20376/06Autumn-Addenda.pdf accessed 3 April 2014].

² Anon ‘Sir David Kennedy’ *Munk’s Roll, Vol V* (Royal College of Physicians). [http://munksroll.rcplondon.ac.uk/Biography/Details/2147 accessed 18th April 2014].

³ Cameron ‘In Memorium, David Kennedy Henderson (1884-1965)’ p. 468.

prevention and amelioration of mental disorders. In recognition for his services to psychiatry he was knighted in 1947. Having by then built an international reputation, his chief professional interests fell to studies of the pre-senile dementias and psychopathic personalities. Through his publications he advocated for greater social and legal compassion towards men and women whom he classified as belonging to the psychopathic states,⁴ and his 1939 text *Psychopathic States* still commands attention within the psychiatric profession today.⁵

Across the decades Henderson helped to establish the careers of such notable British psychiatrists as R. D. Gillespie and Donald Ewan Cameron, occupational therapists Dorothea Robertson and Annie Melrose, and generations of medical students who attended his lectures and clinical demonstrations. It is also thought that Henderson's dynamic approach to psychiatry, which was upheld within Gartnavel well into the 1960s, went on to influence R. D. Laing, the famous 'anti-psychiatrist' of the second half of the twentieth-century.⁶ Such a history shows Henderson's life to have been strewn with professional achievements, but it is undoubtedly his life long adherence to Meyerian teachings that most significantly shaped the course of his career and that of Scottish psychiatry. Suffusing his writing is his adherence to dynamic, or, as Adolf Meyer termed it, psychobiological psychiatry, an approach that placed the patient and their individual life histories at the centre of clinical research and therapeutic treatment. Expositing the teachings of Meyer throughout his career, Henderson did much to uproot the long-established somatic-pathological classificatory systems of Scottish psychiatry, while within Gartnavel he inaugurated modern classificatory systems, administrative techniques, therapeutic treatments and examinatory methods, many of which are now regarded as essential to modern psychiatric practice.⁷ In a letter written by Henderson to Meyer and Mrs Meyer in 1947, we see the affirmation of this allegiance to Meyer. His life's work, he wrote, was to:

⁴ D. K. Henderson *Psychopathic States* (London: Chapman and Hall Ltd, 1939).

⁵ Femi Oyeboade Sims' *Symptoms in the Mind: An Introduction to Descriptive Psychopathology* (Edinburgh: Saunders Elsevier, 2008) pp. 401-413. See also Anon 'Sir David Kennedy'.

⁶ It is interesting to note that Laing, having previously served as registrar at Gartnavel in 1953, analysed patient case records in the 1960s from a theoretical orientation that in many ways upheld the teachings of Henderson. Gartnavel's approach to mental illness had remained wedded to the dynamic approach throughout the 1930s, 40s and 50s, and, as Beveridge demonstrates, Henderson and Gillespie's *Textbook of Psychiatry* 'expressed many of the ideas that Laing was to advance later in his career'. Beveridge *Portrait of the Psychiatrist as a Young Man* pp. 201-202.

⁷ Smith and Swann 'Medical Officers and Therapeutics, 1921-1993' pp. 73-75.

Pass on, as far as possible, the help and type of training which you gave us ... [and] the breadth of view and the sound methods which were instilled into me at an earlier period in my life ...

With my warmest thanks, *and love*^{*8}

Believe me,

Yours sincerely, *and gratefully*

David K. Henderson⁹

In recent years, the impact made by Henderson on Gartnavel, and on Scottish psychiatry as a whole, is gradually being recognised through the works of scholars such as Smith, Swann, Andrews, Scull, and Beveridge.¹⁰ However, with the exception of Henderson himself, little attention has been paid to the most formative period in his training when his adherence to Meyer's psychobiological approach was cemented.¹¹ The historical record, being somewhat blind to these years between 1908 and 1921, ill equips scholars to understand precisely how Henderson built up his own evolving sense of dynamic psychiatry.¹² Neither does current scholarship allow us to understand the extent to which Henderson's pioneering employment of dynamic psychiatry posed a radical challenge to the British psychiatric establishment.¹³

To explore these questions more fully, it is to the early years of Henderson's professional training that this chapter turns. Drawing primarily upon autobiographical texts, personal correspondence and medical literature, I use these material traces of Henderson's private and public life to carve a biography of Henderson that mediates between memory and

⁸ * These highlighted sections were pencil additions to a typewritten letter.

⁹ Correspondence Collection, D. K. Henderson, Box no I/1659/17 in the AMC.

¹⁰ Smith and Swann 'Medical Officers and Therapeutics'. See also Iain Smith and Jonathan Andrews 'The Evolution of Psychiatry in Glasgow During the Nineteenth and Early Twentieth Centuries' in *150 Years of British Psychiatry Volume II: the Aftermath* eds. Hugh Freeman and German Berrios (London: Athlone Press, 1996). Beveridge *Portrait of the Psychiatrist as a Young Man*. Susan Lamb 'Pathologist of the Mind: Adolf Meyer, Psychobiology and the Phipps Psychiatric Clinic at The Johns Hopkins Hospital, 1908-1917' (Unpublished PhD thesis submitted to The Johns Hopkins University, Baltimore, August 2010).

¹¹ Smith and Swann 'Medical Officers and Therapeutics'. Scull *The Insanity of Place/The Place of Insanity*.

¹² For instance, Smith and Swann write that, because of Henderson's previous medical training and high output of published articles, 'there can have been little doubt' that Henderson would succeed Landel Rose Oswald to the post of Physician-Superintendent of Gartnavel in 1921. Yet this statement omits reference to the substantial degree of indifference, sometimes opposition, shown towards Henderson in his early career. See Smith and Swann 'Medical Officers and Therapeutics' p. 73.

¹³ Scull writes that during the 1920s Henderson found himself pressed to speak out against the reductivist orientation of the majority of his contemporaries, but scholars have so far failed to push these observations to their logical conclusion, to ask precisely how Henderson was able to introduce a dynamic approach in a period dominated by somatic-pathological classificatory systems. See Andrew Scull *Madhouse: A Tragic Tale of Megomania and Modern Medicine* (Great Britain: Cambridge University Press, 2005) p. 232.

history.¹⁴ While recognising the partiality of correspondence sources, and the incompleteness of the archive, I present these sources in a manner by which a critical reader may distinguish the relevant data and primary sources, from my own theories and interpretations. Crafting a biography that focuses upon Henderson's medical training and his connection to the Phipps School of psychiatry, I employ a 'spatial lens' through which to portray Henderson's life history within places and spaces recognised as pivotal to his personal and professional development. Navigating archival absence, while remaining attentive to the possible significance of such silences, I endeavour to 'to think and feel' my way into the '[s]cientific temperament, personal characteristics, cultural ambience, intellectual prehistory ... [and] professional experience' of Henderson.¹⁵ Progressively building up a picture of the 'world' which he inhabited, this chapter prepares the ground for a critical engagement of Gartnaveil's case note records, one that is foregrounded in a history of personal experiences, professional relations and the wider socio-medical-geographical context in which they emerged.

Dynamic psychiatry: the formative years

At present there is no more authoritative or livelier written account of the progression made by Henderson throughout the early years of his career than that written by the man himself, and it is therefore to Henderson's semi auto-biography that this chapter initially turns. Published in 1964, *The Evolution* saw Henderson look back, from the prime age of 80, on a long and prestigious career. Spanning two World Wars and traversing both sides of the Atlantic, *The Evolution* was written partly from a historical, and partly from an autobiographical, perspective. The text initially sets out to reveal the unique contributions made by those in Scotland to the progression of Western psychiatry, but it also allowed Henderson to reflect upon, and to integrate his own personal history, among those of his predecessors and his peers. Writing in the introduction to this text, Henderson defended the validity of his subjective stance, claiming:

Although it may be argued that a personal narrative is likely to be unduly narrow and biased it has the possible merit of being more vivid than the wider conspectus of a more detached view.¹⁶

¹⁴ Cheryl McGeachan, Isla Forsyth and William Hasty 'Certain Subjects? Working with Biography and Life-Writing in Historical Geography' *Historical Geography* 40, 12 (2012) p. 171.

¹⁵ Wallace 'Historiography, Philosophy and Methodology of History' p. 12.

¹⁶ Sir David Kennedy Henderson *The Evolution of Psychiatry in Scotland* (Edinburgh: E. & S. Livingstone Ltd, 1964) p. 134.

The merits of his text are well recognised in this chapter, but as I go on to discuss in the conclusion to this thesis, there was a political motivation to Henderson's semi-biography, one that must be kept in mind while assessing its contribution to the historical record. This is because Henderson's text was written partly in response to events in the 1960s, which saw the rise of biomedicine within the psychiatric profession, to the detriment of Henderson's dynamic principles. His personal narrative argued against the increasingly 'mechanistic' stance of modern 'physical methods of treatment' such as drug and electro-shock therapy. By using the autobiographical component of his text to emphasise the personal stories of past patients and practitioners, and the relations of 'empathy' and 'mutual trust' that flowed between them, *The Evolution* strove to reassert the 'human element' of psychiatry, which Henderson insisted 'means so much'.¹⁷

In this chapter *The Evolution* is used as a guide from which to begin to piece together the history of Henderson's medical training. Yet, while relying on Henderson's retrospective analysis of the years 1907-1921, this chapter will compare and contrast this autobiographical – indeed, as I will argue, somewhat mellowed - historical account with a set of records that allow a more immediate, empirically informed analysis of these crucial developmental years. Within the Alan Mason Chesney Medical Archives, situated at the Johns Hopkins Medical School, Baltimore, Maryland, a correspondence collection, written between Meyer and his colleagues, provides substantial new insights into the development of Henderson's early career. For, as Meyer was, in many ways, at the centre of a network of medical trainees, each bound by the practice of psychobiology, the letters that flowed between these men and women allow for both an intellectual and a social history of the psychiatric profession to emerge. Within this correspondence collection, a good proportion of which passed between Henderson and Meyer, a history transpires that not only complements, but also on occasion contests, that which is recollected in *The Evolution*. These letters reveal a depth of ambition, frustration and motivation that Henderson's retrospective analysis sometimes fails to capture, while, concurrently, also revealing something of the day to day routines, even the mundane events, which did so much to shape his professional outlook. Most significantly, they attest to the gradual development of Henderson's own dynamic methods of examination, interpretation, case note taking and case history construction; sources that are so central to this thesis. It is therefore to the

¹⁷ Ibid pp. 222-23.

disequilibrium, as well as the correlations, between *The Evolution* and contemporary correspondence, that a history of these early years emerges. ‘Difference’ as J. D. Dewsbury states is what ‘makes the social alive, political, invigorating’ and therefore this chapter presents the disequilibrium between these sources with confidence and with a faith of being ‘solicitous of affect’ while ‘nervous and tentative about the consequences of that solicitation’.¹⁸

One final preliminary remark must be made about the history of Meyer, as he played such a substantial role in shaping Henderson’s career, and through him, the evolution of Scottish psychiatry in the twentieth-century. The life of Meyer has, in the last 30 years, attracted the interest of scholars including Ruth Leys, Andrew Scull and Gerald Grob, while back in the 1950s Eunice Winters collated and edited Meyer’s published works into four substantial volumes.¹⁹ My understanding of Meyer’s professional history is based in part upon these publications, but it is to the work of Susan Lamb on Adolf Meyer in her dissertation thesis and unpublished manuscript *Pathologist of the Mind* that this thesis is most heavily indebted.²⁰ Leaning upon Lamb’s research, which most diligently captures the history of Meyer’s professional career, this chapter intertwines a history of Meyer with that of Henderson. Directed towards the development of Meyer’s case note taking guides and the evolution of the staff meeting, this chapter lays foundations for following chapters, which examine Henderson’s reproduction of such dynamic case note records within Gartnavel.

From undergraduate to intern, 1907-1908: Thomas Clouston (1840 – 1915) at Morningside

As Henderson looked back, with great modesty, on the early years of his medical training between 1901 and 1907, he recalled it was as a fortuitous and determined young medical student of the University of Edinburgh that his adverse reaction to the ‘warm atmosphere’, the ‘smell of anaesthetic’ and the ‘glittering surgical instruments’ of the operating theatre, pushed him towards a career in psychiatry. Fearing the dire consequences of failing to perform in a surgical emergency, Henderson found refuge from the attacks of cold sweat,

¹⁸ J. D. Dewsbury ‘Performative, non-Representational, and Affect-Based Research: Seven Injunctions’ in *The SAGE Handbook of Qualitative Geography* eds. Dydia DeLyser et al (London: Sage Publications, 2010) p. 332.

¹⁹ Ruth Leys ‘Meyer, Watson, and the Dangers of Behaviourism’ *Journal of the History of Behavioural Studies* 20 April (1984) 128-149. Scull *Madhouse: A Tragic Tale of Megalomania and Modern Medicine*. Gerald Grob ‘Adolf Meyer on American Psychiatry in 1885’ *American Journal of Psychiatry* 119 (1962-1963) 1135-42. Meyer *The Collected Papers of Adolf Meyer, Vol. I- IV*.

²⁰ Lamb ‘Pathologist of the Mind’.

palpitations and faintness, which accompanied his visits to the operating theatre, when his interest turned to the vivid case histories presented by the famed Edinburgh physician, Dr Thomas Clouston, in his text *Clinical Lectures on Mental Diseases*.²¹

By the turn of the twentieth-century, Clouston (see figure 2), who was appointed Physician-Superintendent of the Royal Edinburgh Asylum, Morningside in 1873, was the ‘acknowledged doyen of Scottish Psychiatry’.²² Described by Henderson as having toured the wards of Morningside wearing a Prince Albert frock coat, striped trousers and ‘the usual tall silk hat’, Clouston was characterised by his contemporaries as an ‘energetic, driven clinician who expected high standards from both himself and others’.²³ During his 35 years spent as Superintendent of Morningside, Clouston gained a strong professional and public reputation, as his high output of published works, his breadth of knowledge, plus his distinction as Edinburgh University’s first lecturer in mental diseases, gained him respect and renown. His *Clinical Lectures on Mental Diseases* (1883), which went into six editions, became a monumental feature on the landscape of Scottish psychiatry,²⁴ whilst *The Hygiene of Mind* (1906) and *Before I Wed* (1913) found a wide readership in professional and public audiences alike.²⁵ Moreover, Clouston accomplished an ambitious rebuilding programme, aiming to improve patient care and to ease the pressure put upon the existing establishment by an ever-increasing number of ageing pauper patients.²⁶ He famously tore down the ‘prison like walls of the old airing courts’, closed the refractory wards, and, in an attempt to attract more private, fee paying patients, had a new Gothic style mansion erected in 1894 which catered for a upper-class clientele.²⁷ By the turn of the century, Morningside consisted of two divisions that reflected the Scottish class system

²¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 137-138.

²² Born 22nd April 1840, Clouston was the youngest of four sons born to Robert Clouston, an Orkney Laird, and Janet Smith of Stromness. Having studied medicine at Edinburgh University and graduated MD in 1861, he initially worked as an assistant physician to Dr David Skae at the Royal Edinburgh Asylum. This was followed by his appointment as Medical Superintendent of the Cumberland and Westmorland Asylum, Carlisle in 1863; and, after ten formative years spent ‘learning the practicalities of asylum management’ and producing a profusion of well-received medical publications, he was appointed superintendent of Morningside, a position he held until 1908. Margaret. S. Thompson ‘The Wages of Sin: the Problem of Alcoholism and General Paralysis in Nineteenth-Century Edinburgh’ in *The Anatomy of Madness Vol III The Asylum and its Psychiatry* eds. Roy Porter et al (London: Tavistock, 1988) p. 316. [<http://www.oxforddnb.com/view/article/38634>, accessed 3 April 2014]. See also Allan Beveridge ‘Clouston, Sir Thomas Smith (1840-1915)’ *Oxford Dictionary of National Biography* (Oxford University Press, 2004) online edition.

²³ Henderson *The Evolution of Psychiatry in Scotland* pp. 137-138.

²⁴ Davis *The Cruel Madness of Love* p. 55.

²⁵ Beveridge ‘Clouston, Sir Thomas Smith (1840-1915)’.

²⁶ Davis *The Cruel Madness of Love* p. 49.

²⁷ Beveridge ‘Clouston, Sir Thomas Smith (1840-1915)’.

‘and all of its inequalities’: with West House for rate aided patients and Craig House for those who were fee-paying.²⁸

On his day-to-day rounds of Morningside, Henderson recalled Clouston’s presentation of individual patient case histories as ‘most illuminating’. Clouston’s suggestions regarding case note taking ‘closely approximated the later formulations of Adolf Meyer in relation to the concept of the whole man’ as ‘every word and every act’, every ‘physiological and pathological’ symptom presented by a patient, was envisaged as laden with significance.²⁹ For Clouston, mental illness was firmly viewed from a materialist, somatic-pathological perspective, which envisaged mental disorder as the aberrant ‘functioning’ of a complex and highly variable human physiology.³⁰ Rather than assuming a reductivist materialist model, however, which aligned the causation of mental illness to structural defects situated in the brain, Clouston identified an array of physiological factors such as an excess of work, changes in blood supply, over-indulgence of the ‘passions’ and a series of more tangible variables such as age, sex and temperament, all understood to disrupt the ‘normal’ functioning of the brain.³¹ Greatly influenced by the prevailing climate of scientific naturalism,³² Scottish ‘common sense’ philosophy and nineteenth century ideals of ‘moral therapy’, Clouston’s publications infused religious and scientific principles in an attempt to exhort healthy standards of living.³³ Harking back to the works of late eighteenth-century Edinburgh physicians such as Alexander Crichton,³⁴ Clouston theorised that:

²⁸ Davis *The Cruel Madness of Love* pp. 49-50.

²⁹ Henderson *The Evolution of Psychiatry in Scotland* p. 140.

³⁰ Berkenkotter *Patient Tales* p. 85.

³¹ For a more in-depth assessment of the differences between reductivist and functional concepts of mental illness in the 19th century see Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ p. 390. See also Berkenkotter *Patient Tales* p. 85 and for an example of Clouston applying these theories to a diagnostic category see Thomas Clouston *Clinical Lectures on Mental Diseases* (London: J. & A. Churchill, 1892) pp. 26- 35.

³² Scientific naturalism is described by historian Dora B. Weiner as stemming from a German philosophic tradition. ‘Formulated in 1799 by Fredich Wilhelm Joseph von Schelling *Naturphilosophie* [envisaged] ... that man’s body and mind were part of ever-changing Nature and that physicians, adapting to Nature, had the power to heal’. Long before Meyer was envisaging mental illness as a reaction to environment, German natural philosophers were envisaging the individual mind as being shaped by ‘sensory messages ... drives, emotions and the products of memory and imagination’. Excessive stimuli or ‘disharmonious combinations’ of emotions, senses etc were seen to produce mental ‘derangement’. Dora B. Weiner ‘The Madman in the Light of Reason. Enlightenment Psychiatry. Part II. Alienists, treatises, and the Psychologic Approach in the Era of Pinel’ in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 291.

³³ Beveridge ‘Clouston, Sir Thomas Smith (1840-1915)’.

³⁴ Dora B. Weiner writes that Crichton, an Edinburgh medical student, would have been absorbed in the philosophies of Baconian empiricism, Lockean psychology and Scottish “common sense” philosophy. His teaching ‘On the Passions, considered as Causes of Mental Derangement, and on their Modification, and Corporeal Effects’ enjoined a physiological understanding of the emotions to an understanding of their effects on mental functioning. Weiner ‘The Madman in the Light of Reason’ p. 292.

The treatment of mental disease is in many cases a fight against morbid, unsocial ways, degraded tendencies, and idle, selfish, listless, uninterested habits of mind, and we fight these by moral means, by employment, amusement, good food, fresh air, exercise, and good hygienic conditions of life.³⁵

With somatic-pathological, common sense philosophies and moral conceptions intertwined in Clouston's writings, the day-to-day treatment of patients consisted of a regime of 'physical methods' combined with 'moral treatments'.³⁶ Clouston imposed upon his patients a 'highly regimented programme of exercise, work and entertainment' and it was in accordance with such a somatic, and humanistic, outlook that Henderson was drawn to a career in the psychiatric profession.³⁷ Despite being warned of the slow and often stunted professional progression faced by many young psychiatrists, Henderson searched out an interview with Clouston and was appointed a clinical assistant on the staff of the Royal Edinburgh Asylum.³⁸

Henderson recalled that, as he entered the asylum, the 'prestige and eminence' of Clouston 'was felt throughout the entire hospital'. Working alongside medical staff such as Dr. R. Dods Brown, Dr C. Macfie Campbell and Dr A. W. Neill, he was introduced to the administrative side of psychiatric practice as he learned to write up case notes and case reports in ledgers which, he recalled, were 'so large that they had the merit of never being mislaid'.³⁹ All junior assistants used formal case note sheets - introduced to the asylum by Clouston - and it was under Clouston's administrative regime that Henderson first learned to record a case.⁴⁰

³⁵ Thomas Clouston 'Physician-Superintendent's Annual Report for the Year 1885' (Morningside: Royal Edinburgh Asylum) quoted in Beveridge 'Madness in Victorian Edinburgh' p. 144.

³⁶ Beveridge 'Madness in Victorian Edinburgh' p. 144.

³⁷ Allan Beveridge 'Thomas Clouston and the Edinburgh School of Psychiatry' in *150 Years of British Psychiatry, 1841-1991* eds. German E. Berrios and Hugh Freeman (London: The Royal College of Psychiatrists, 1991) p. 144. Manual labour on the Asylum's farms, and in its workshops, kitchens, stores and laundry was felt to be beneficial to the health of patients, and this regime of work and exercise was offset by patients' participation in games and social events that consisted of bowls, cricket, curling and cards alongside concerts, lectures, and dances. Davis *The Cruel Madness of Love* pp. 52-53. In terms of physical therapies, physical labour was employed alongside the use 'drugs, electricity, blisters to the head, baths and attention to diet'. Beveridge writes that in his later years, Clouston's 'enthusiasm for drugs waned' and he prescribed the lowest possible doses for his patients. Also his use of electrical therapies seems to have waned, with little evidence emerging from case note records that this method was used in the latter years of the 19th century. Instead Clouston made use of thyroid extract with the aim to produce 'short-lived fever[s]', whilst the use of cannabis indica and bromides was introduced as a particularly effective sedative. Beveridge 'Madness in Victorian Edinburgh' p. 145.

³⁸ Henderson *The Evolution of Psychiatry in Scotland* p. 136.

³⁹ *Ibid* pp. 141-142.

⁴⁰ Berkenkotter *Patient Tales* p. 85.

Despite Henderson being introduced to the practice of psychiatry under such impressive auspices, by the turn of the century Clouston was becoming known as the ‘Grand Old Man’ of psychiatry, while the building he designed in the Victorian era lacked the amenities of a modern mental institution.⁴¹ What lay behind the imposing façade of Morningside was a dire lack of medical facilities. With no operating theatre there was little provision for medical emergencies; and, with no clinical side rooms or admission units, patients young and old, demented or recovered, quiet or disturbed were housed alongside one another, which, recalled Henderson, was the source of great distress for many patients and their families.⁴² Under such conditions, Henderson’s training was - like the majority of his British contemporaries - bound to the administrative duties of a large country asylum. This, wrote Henderson in *The Evolution*, contrasted sharply with psychiatric training in Europe.⁴³

In France and Germany, where the study of mental illness was more often conducted in university hospitals rather than country asylums, young physicians were drawn towards centres of research such as the Parisian Salpêtrière and Bicêtre Hospitals, as well as the Nussbaumstrasse Psychiatric Clinic, Munich.⁴⁴ In Paris theories of the subconscious mind, deriving from the works of neurologists Jean-Martin Charcot and his critics Hippolyte Bernheim and Pierre Janet on hypnosis and suggestive therapy, paved the way for a dualistic model of mental disorder to emerge by the turn of the century.⁴⁵ Patients whose bodies failed to show organic changes of the brain or nervous system, but whose behaviour evidenced psychological disturbances such as phobias, anxiety or compulsions, began to be identified as the ‘functional neuroses’ or the ‘psychoneuroses’, engendering a significant, if somewhat spurious distinction between psychoneurotic and psychotic cases.⁴⁶ In Germany during this period, it was likewise the gaze of the neurologist and clinical psychiatrist, rather than the asylum physician, which steered the progression of medical

⁴¹ Beveridge ‘Thomas Clouston and the Edinburgh School of Psychiatry’ pp. 365, 375.

⁴² Henderson *The Evolution of Psychiatry in Scotland* p. 148.

⁴³ Henderson *The Evolution of Psychiatry in Scotland* pp. 142-146.

⁴⁴ Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ p. 391.

⁴⁵ By the turn of the twentieth century the neuroses had taken on a different meaning. Appropriated by Freud, the neuroses came to distinguish disorders characterized by compulsive or phobic thoughts and behaviours which failed to evidence somatic disorder of the nervous system. The term psychoses came to delineate disorders characterized by hallucinations or delusions that evidenced an individual’s loss of touch with reality, which originated from a fundamental personality trait. See German Berrios ‘Descriptive Psychiatry and Psychiatric Nosology’ in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 362-63.

⁴⁶ Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ p. 390.

theory. Clinicians such as Richard Krafft-Ebing and Emil Kraepelin, alongside bacteriologists such as Fritz Schaudinn and August Wasserman, brought renewed hope and enthusiasm to clinic-pathological studies of mental disease through their discovery of the syphilitic antibody that caused the mental disorder, contemporarily known as general paralysis of the insane.⁴⁷

Scottish psychiatry was, by comparison, isolated from the scientific trends of general medicine. At Morningside they ‘only dealt with psychotic patients’, while ‘the psychoneurotics’, Henderson wrote, ‘were regarded as the particular province of neurologists who treated them in the wards of the general hospitals or in private nursing homes’.⁴⁸ Moreover, notwithstanding Clouston having affiliated the Edinburgh Royal Asylum with the Edinburgh Royal Infirmary and the Central Pathological Laboratory of the Scottish Asylums, little progress was made in the study of pathology.⁴⁹ In an environment where the study of mental disorder was largely confined to the study of the psychoses, Henderson began his career by administering physical remedies to patients whose mental disorders were traced to physical traumas such as childbirth, fatigue, the menopause and physical injury.⁵⁰ These patients were cared for alongside those suffering from alcoholism, syphilitic infection and drug addictions, and, under such conditions, Morningside could offer a rather pessimistic picture of psychiatry. By day, Henderson recalled that a large number of nurses attended these enfeebled patients, enabling the psychiatrists to carry out their duties, but by night a shortage of nursing staff increased the institution’s reliance on the use of locked rooms and the prescription of sedatives, which did much to harm the relations between patients and medical staff.⁵¹ The care of patients was in many cases consigned to the provision of nourishment, adequate comfort and the

⁴⁷ On the development of the clinic-pathological model in the early twentieth century see Herbert Weiner ‘Psychosomatic Medicine and the Mind-Body Relation’ in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 786.

⁴⁸ Henderson *The Evolution of Psychiatry in Scotland* p. 142. The differentiation between psychosis and psychoneurosis is made in 1918 by L. G. Lowry in ‘The Insane Psychoneurotic’ *American Journal of Psychiatry* 75 (1918) 53-80 p. 53. Lowry writes ‘It is very difficult to define simply and accurately the differences between psychoneurosis and psychosis. In both the symptoms may be of the same type – pains, somatic ideas, emotional and ideational difficulties. The great outstanding difference seems to be that the psychoneurotic resist the ideas, where the psychotic accept the ideas, incorporate them into the personality and elaborate them’.

⁴⁹ Beveridge ‘Thomas Clouston and the Edinburgh School of Psychiatry’ p. 380. See also Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ pp. 390-91. See also Andrews ‘Death and the Dead-House in Victorian Asylums’ p. 20.

⁵⁰ *Ibid* p. 140-142.

⁵¹ As Beveridge has argued, it is evident that by reading the case histories contained within Clouston’s book on *Clinical Lectures and Mental Diseases* that the relations between Clouston and his patients was often one of struggle, with many ‘battles between asylum staff and patients’ being recorded. See Beveridge ‘Thomas Clouston and the Edinburgh School of Psychiatry’ pp. 367-68.

prevention of bedsores, and the work offered to a junior member of staff could be repetitive, unscientific and uninspiring.⁵²

Henderson's introduction to the psychobiological case note record: Charles Macfie Campbell (1876-1943) at Morningside

It was therefore fortuitous that Henderson should come under the tutelage of Clouston's junior assistant, Charles Macfie Campbell (see figure 3), who introduced Henderson to a more optimistic, dynamic approach to psychiatry. Campbell, born in Scotland in 1876, was educated at the University of Edinburgh from which he received a MA degree in 1897, and in 1902 he received his medical degree M.B. Ch.B.⁵³ Described by Henderson as a small, active, stockily built man bursting with enthusiasm, Campbell had studied under such famed psychiatrists and neurologists as Franz Nissl in Heidelberg, Pierre Marie in Paris and the then lesser-known Swiss émigré psychiatrist Meyer in New York.⁵⁴ Fluent in both French and German, Campbell was an enthusiastic advocate of Kraepelinian classificatory systems and Meyer's psychobiological formulations. A skilled student of neurology and a keen expositor of Freud's and Jung's psychoanalytic teachings, a ward round under the guidance of Campbell, wrote Henderson 'became an exciting adventure':

The dull and lustreless eyes of his patients which looked out so unseeingly acquired new light, hope was re-awakened and even their stereotyped utterances and bizarre conduct could be interpreted and understood.⁵⁵

Under Campbell's tutelage, Henderson was taught to think of mental illness in terms of 'reaction types', rather than placing patients within rigid diagnostic categories. Encouraged to note the contents of patients' utterances, and to question the aetiological significance of a patient's social environment, he began to craft his case note reports along psychobiological lines.⁵⁶ 'Strange new terms', wrote Henderson in an article dedicated to the memory of Campbell in 1943:

Such as "flight of ideas," "distractibility," "depersonalisation," and the incongruities of mood and manner and thought of the schizophrenic at last became understandable.

⁵² Henderson *The Evolution of Psychiatry in Scotland* p. 149.

⁵³ Harry C. Solomon 'Dr Charles Macfie Campbell 1876-1913' *American Journal of Psychiatry* 100 (1943) 438-441.

⁵⁴ Henderson *The Evolution of Psychiatry in Scotland* p. 146.

⁵⁵ *Ibid* p. 147.

⁵⁶ *Ibid*.

These, of course, were the days of Kraepelinian differentiation, but even at that time Campbell, having profited by his experience at the psychiatric unit, Wards Island, New York, was interpreting his case material in the light of Adolf Meyer's life history and personality studies; in consequence his case records and summaries were concise presentations of the facts in each individual case which could be understood and worked with.⁵⁷

Encouraged by Campbell to look past the dreary appearance of many of his chronic patients and to invest their personal stories with a deeper level of meaning, Henderson's eyes were opened to the renewed sense of optimism and inquisitiveness that was gathering pace upon the Continent and North America.⁵⁸

Over the first three-months during which Henderson worked as an assistant to Campbell in Craig House, he was already being noticed as a promising recruit to the psychiatric profession. In a letter written by Campbell to Meyer in the winter of 1907, Campbell began by summarising the somewhat bleak dispersal of poorly educated practitioners within Scottish psychiatric asylums. As the letter went on, however, he reflected with satisfaction upon his own incremental advance made at Craig House, where he had begun training a new clinical assistant (later revealed to be Henderson) in methods of case note taking. By highlighting sections of his letter I draw out significant passages upon which to elaborate. The letter in its entirety, however, offers an intriguing perspective on the state of the Scottish psychiatric profession.

⁵⁷ D. K. Henderson 'In Memoriam, Professor Charles Macfie Campbell' *American Journal of Psychiatry* 100 (1943) 441-442.

⁵⁸ Whilst Clouston's most significant contribution to psychiatry was arguably his description of the 'Insanity of Adolescence', Campbell was in many ways far advanced of Clouston's teachings. By the turn of the century, Clouston's description of the Adolescent Insanities had become overshadowed by the work of Emil Kraepelin, and it was to Kraepelin and Meyer that Campbell's methods of examination and diagnosis were theoretically aligned. Henderson *The Evolution of Psychiatry in Scotland* p. 147.

CRAIG HOUSE,
MORNINGSIDE DRIVE
EDINBURGH

Dear Professor Meyer

I should have written to you sooner but delayed writing until I saw how the general situation here was developing. Rutherford resigned from the Crichton on a pension of £1600; at the time he left he was drawing, I believe, £2400. No one ever accused him of knowing anything about mental disease. Eastbrook, of Ayr, an old assistant of Clouston and a rather intelligent man has got the Crichton post. That left Ayr vacant and two senior men here both applied for it – Rutherford the first assistant and Mr Rae his junior, and McRae has just been appointed ... Personally he does not attract me much, and he does not seem to think that a frank discussion of the subjects which interest us both would be worth having ... Both Robertson and he talk with an air of finality about all the clinical phenomena of general paralysis in bacteriological terms – there is an invasion, the bacilli are being dissolved, the infection is mixed, etc ... McRae probably leaves for Ayr next month, in which case **I go down to the West House, where the poorer patients are.** There I shall have one side of the house: I shall have a large number of patients - ... **I expect to have my time less cut up, as it takes less time to shake hands with a £40 than with a £300 patient, so that Clouston's visit is usually shorter ... and does not take up the best part of the forenoon ... I have just got a clinical assistant here, and have started him on the case-taking outlines, so for the first time since America was discovered a junior here is learning to make a thorough examination of a case ... I hand out various things to Dr Clouston from time to time – your article on dementia praecox, your clinic cases, a type-written record etc and he is always much interested ... can we not persuade you to prepare the medical mind for ultimate truth by some tentative formulations or presentation of limited conclusions? It always seems to me that there is such a dearth of good case-material well discussed in our literature ...** As to this climate -! I am glad that none of my American friends have been here the last two months.

I shall write soon again ... With best regards to Mrs Meyer and yourself I am yours truly C. Macfie Campbell⁵⁹

Among Campbell's report of dissatisfaction, aimed towards many of the leading figures of Scottish psychiatry, this letter demonstrates that which later proved a significant professional allegiance, forged between Scottish and North American psychiatrists. From within Morningside, Meyerian psychiatry was slowly seeping into the consciousness of the very highest to the lowest echelons of the medical staff; and, as Campbell pamphleteered Clouston with Meyer's journal articles and typewritten clinical cases, he set to work with

⁵⁹ Individual Correspondence Charles Macfie Campbell, Correspondence Folder I/595/I dated 30th November 1907, AMC.

Henderson, introducing him to Meyerian case taking outlines. As suggested in his letter, Campbell's championing of Meyerian methods was not always a resounding success, sometimes falling on deaf ears. 'I remember so well', wrote Henderson in 1943:

[H]ow amusingly Campbell used to tell the story of how ... he had prepared a rather lengthy summary of an interesting case which he handed to Sir Thomas Clouston. Clouston had not been accustomed to such meticulous case-work, so glancing at it for a moment or two he returned it to Campbell saying: "But, Campbell it would take me half an hour to read this!"⁶⁰

Moreover, as Campbell wrote to Meyer, gently entreating him to formulate more fully his ideas and publish his case-materials, this highlights the fact that, although Meyer published extensively, his writings were often thought 'convoluted, longwinded and esoteric to a fault'.⁶¹ While he persuasively demonstrated his psychobiological principles to his colleagues, they were deprived of a single, unifying text that could communicate Meyer's clinical methods and medical philosophies to others.⁶² The transmission of psychobiology to a British audience was unlikely to be facilitated through Meyer's published works alone; rather, it was through his colleagues that his ideas would spread and infiltrate British psychiatric practice. At Morningside, it was therefore from within an experimental space, situated somewhat apart from Clouston's unremitting rounds and daily routines, that psychobiology was promulgated. In the poorer wards of West House, where rounds were not so long disturbed by Clouston's daily visits, a more 'thorough' examination of patient cases was thought possible. Yielding a greater degree of autonomy, it was here that Campbell's clinical practices, rather than text-book learning, introduced Henderson to psychobiology.

Over the next three months, Campbell and Henderson worked together in West House, and it was in these wards that Henderson found himself encountering a patient population predominantly made up of the acutely ill and enfeebled. Among the West House population it was the Orcadian patients, who populated the rate-aided wards, whom Henderson most vividly recalled. These patients, noted Henderson, shipped from Kirkwall in the Orkney Islands, displayed mental symptoms that were often 'culture bound', coloured by the 'primitive, superstitious' beliefs of isolated island communities. Henderson

⁶⁰ Henderson 'In Memoriam, Professor Charles Macfie Campbell' pp. 441-442.

⁶¹ Lawrence Davidson 'The Strange Disappearance of Adolf Meyer' *Orthomolecular Psychiatry* 9 (1980) 2 135-143 pp. 137-38.

⁶² Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 332.

described one such patient, named ‘Sandy’, as a ‘great character, a most obliging, courteous, scholarly man’. On the ward it was noted he ‘kept his head covered with a large bandanna handkerchief to ward off the baleful glances of ‘the Cod’[;] a female charge nurse, whose only misfortune was to have bulging fishlike eyes’.⁶³ Judged alongside the rate-aided patients of the city of Edinburgh, their beliefs, recalled Henderson, would have made for a very poor prognosis. But such patients, who were easily recognised due to their ‘sing song’ Orcadian accent, were judged in accordance to the social specificity of their beliefs.⁶⁴ Even within these first few months, it was the individual life histories and social backdrops of patients that attracted Henderson to the study of mental illness symptoms and their environmental specificities.

After working with Campbell for another three months, Henderson had proven himself a valuable member of the clinical staff, and, with a glowing report of introduction, Campbell wrote to Meyer asking that his friend and clinical assistant ‘Dr D. K. Henderson’ be employed by Meyer at the New York Psychiatric Hospital. As the following letter demonstrates, Campbell was hoping to invest Henderson with a working knowledge of the psychobiological principles of Meyerian psychiatry. In doing so, he endeavoured to provide members of a younger generation with the knowledge to reform Scottish psychiatry, and to override the dominating materialist principles embedded within the minds of the ‘senior men’ presiding over the individual asylums.

⁶³ Henderson *The Evolution of Psychiatry in Scotland* pp. 149-50.

⁶⁴ Within this era, we see a concerted effort made by psychiatrists such as Bleuler, Freud and Meyer to explore the environmental contexts and social specificities of asylum patients. For a discussion of Bleuler and the impact that the specific language associated with German-Swiss peasants made to his understanding of schizophrenia, see Philo *A Geographical History* p. 28. In years to follow the influence of anthropological and psychological studies can be seen in the works of Sigmund Freud in texts such as *Totem and Taboo* and post WWI publications such as Rivers *Instinct and the Unconscious*.

347 CRAIG HOUSE

Royal Asylum,
Morningside,
Edinburgh.

Dear Professor Meyer

... You expressed a willingness to take on a clinical assistant from this side, if we could forward a suitable man. I should like very much to see my friend Dr D. K. Henderson on the staff of the Institute; he graduated last year and spent three months as clinical assistant at Morningside. I tried, so far as the arrangements permitted, to give him a fair start in psychiatric work, and he showed great interest in the work ... He is bright and intelligent, honest in his work and not afraid of doing too much; socially he is a general favourite.

... I am sure that we should be much indebted to you if you could train some men for us. As we have no central institute in Scotland which can have some authority over the individual asylums there is really no means of reaching the senior men, and enlisting their sympathies. The only hopes lie with the young graduates, and they are as a rule neglected ; so long as they are socially active, nothing else is demanded of them. I should like immensely to see Henderson spend a year or two with you and then return to till the ground here...

I am
Yours truly
C. Macfie Campbell⁶⁵

It was due to this trans-Atlantic network of professional relations that Henderson was uprooted from Morningside and, after completing his appointment as Clinical Assistant to Dr Alexander Bruce at the Royal Infirmary, Edinburgh, set sail to New York, to work under Meyer at the Pathological Laboratory of the New York State Hospitals, Wards Island. Campbell, to his great surprise, was also offered the position of Senior Clinical Assistant to Meyer. ‘Your proposition’, wrote Campbell in reply, ‘hit my furnishing preparations like a cyclone and scattered sideboards and carpets past recall’. ‘I thought’, continued Campbell ‘that my path was chosen’ but, after being offered an opportunity to

⁶⁵ Individual Correspondence Charles Macfie Campbell, Correspondence Folder I/595/I dated 28th March 1908 AMC.

work once again with Meyer, he resigned his post at Morningside with little hesitation.⁶⁶ Accompanied by his new wife, Campbell took the opportunity to meander his way through Europe, visiting the laboratories of Alois Alzheimer, walking through the Volksgarten of Vienna with Freud, and meeting among others, Frederick Mott, Nissl, Pierre Marie and Ernest Jones, as he juggled the life of a tourist with that of an aspiring psychiatrist during this most eclectic of honeymoons.⁶⁷

The spirit of adventure, of international and interdisciplinary collaboration, which drove Campbell throughout his career would undoubtedly have proved infectious to Henderson. In September 1908 the pair were reunited in Manhattan, and formed part of Meyer's clinical and neuropathological research team. Assisting with both undergraduate and postgraduate teaching, it was over the next two years that Henderson's life long adherence to the teachings of Meyer began to be forged.

Historical origins of psychobiology: clinical psychiatry, evolutionary theory, pragmatist philosophy and their combination by Adolf Meyer (1866-1950)

University education

Adolf Meyer (see figure 4) was born into a rural Swiss family in 1866 and, after choosing to pursue the career of a medic, underwent his undergraduate degree at the age of 19 at the University of Zurich. His medical training, writes Lamb, was 'cast in the Germanic model' and his courses consisted of 'physiology, anatomy, pathology, zoology, obstetrics, neurology, organic and inorganic chemistry', combined with 'pharmacology' 'surgery' and lectures on 'laboratory technique and work with patients'. Following advanced classes in 'Pathological Anatomy' and 'Illnesses of the Nervous System', Meyer earned his medical degree in 1890.⁶⁸ Desirous to broaden his medical training, he travelled first to Paris to study under the French neurologist and anatomical pathologist Charcot, and then to Edinburgh to study alongside the Scottish physician, Francis Caird.⁶⁹ In Edinburgh, Meyer

⁶⁶ Individual Correspondence Charles Macfie Campbell, Correspondence Folder I/595/3 dated 8th April 1908, AMC.

⁶⁷ Individual Correspondence Charles Macfie Campbell, Correspondence Folder I/595/I dated 2nd July 1908 and written on paper headed the 'Grand Hotel Hungaria, Budapest (Hongrie)', AMC.

⁶⁸ Lamb 'Pathologist of the Mind' pp. 27-29.

⁶⁹ Francis Caird 1853-1926 was born and educated in Edinburgh. As an undergraduate at the University of Edinburgh, he assisted Lord Lister's wards, serving as a dresser, and he 'subsequently practised Listerian

attended a lecture given by Clouston, later recalling it was from his engagement with Scottish psychiatry that he was introduced to the concept of the human organism reacting to both physical and moral therapies.⁷⁰ Moving on to London, Meyer shadowed the eminent neurologist Hughlings Jackson on his clinical rounds, and was deeply impressed by Jackson's 'common sense' approach to the study of the nervous system and his application of the evolutionary theory to the study of mind and body.⁷¹ Meyer was nonetheless troubled by the bedside manner of Jackson, as he reflected: 'The patient's disease held attention to the exclusion of the patient'.⁷² Such a disjointed relationship between neurology and psychology repelled Meyer from wholeheartedly following Jackson's lead; instead, it was the work of the London neurologist William Gowers, who intertwined a neurological career with an interest in psychology, that Meyer found more satisfying. As Gowers paid particular attention to the medical histories of his patients, Meyer, who was initially training as a neurologist, was gradually moving away from his sole preoccupation with the brain and venturing towards an exploration of the 'whole' person, the mind and the environment, in which it functioned.⁷³

Returning to Zurich in 1890 to produce his doctoral thesis, Meyer sought the supervision of the neuro-anatomist August Forel, who furnished him the brain of a chameleon, assigning a task that focused upon the 'nucleus of the motor nerves of the eye of this particular argus'.⁷⁴ By searching out Forel for doctoral supervision, Meyer placed himself under a promoter of the 'Nancy School' of psychiatry, whose neurological research was complemented by his commitment to the study of patients' 'unconscious' mental processes.⁷⁵ Meyer later recalled that in Forel's teaching clinics demonstrations of hypnotic

techniques of antiseptis ... and aseptic surgery'. By the time of Meyer meeting Caird, Caird was establishing himself as a gastrointestinal surgeon. See 'History of the Chair of Clinical Surgery' *The University of Edinburgh* online edn.

[http://www.ed.ac.uk/polopoly_fs/1.55988!/fileManager/History%20of%20the%20Chair%20of%20Clinical%20Surgery.pdf accessed 4 April 2014] p. 3.

⁷⁰ Lamb 'Pathologist of the Mind' pp. 29-31.

⁷¹ Hughlings Jackson (1835-1911) is notable for rejecting contemporary metaphysical concepts of the mind, and promulgating an approach that adapted ideas of evolutionary physiology to the study of neurology. See George K. York III and David A. Steinberg 'Hughlings Jackson's Neurological Ideas' *Brain, a Journal of Neurology* 134 (2011) 3106-3113.

⁷² Adolf Meyer quoted in Lamb 'Pathologist of the Mind' p. 30.

⁷³ Lamb 'Pathologist of the Mind' p. 31.

⁷⁴ Adolf Meyer 'My Experience with American Psychiatry' unpublished manuscript dated 1898, X/1/27 AMC p. 95.

⁷⁵ Forel, a well known neuro-pathologist and psychiatrist, laid the foundations for the neuron theory, which posited that the central nervous system was cellular in nature. He was also known for championing the rights of women to access birth control, a campaigner for temperance, was against anti-Semitism and a

and suggestive therapies were carried out which ‘consisted of a trinity of patient, student, and doctor’.⁷⁶ This method, of carrying out research and demonstration in front of patients and students, was common to Continental medical practice, and provided the blueprint for Meyer’s later formulation of the staff meeting within North American asylums. Upon his graduation, Meyer was therefore equipped with a diverse arsenal of clinical practices and psychiatric theories with which to begin fashioning his own approach to the study of human mental functioning.

Kankakee, the Eastern Illinois State Hospital

In 1892 Meyer emigrated to North America to pursue a career in neurological research, and, following several baulked attempts to carve a career in Chicago, he was employed as a pathologist at the Eastern Illinois State Hospital for the Insane, Kankakee. Here Meyer carried out autopsies of deceased asylum patients, while also conducting microscopic studies of tissues, blood, urine and sputum samples. Housed within the morgue, there was little necessity for Meyer to interact with patients upon the wards. Nonetheless, as his work progressed, he began to influence the treatment and examination of the hospital’s living patients.⁷⁷ At his very first autopsy, Lamb writes, he was ‘observed with “critical curiosity” by Kankakee’s physicians’. Pointing towards the syphilitic lesions on the face and skull of a deceased patient, he noted that ‘no medical history or observations’ of syphilitic infection had been recorded in the hospital’s case books before the patient’s death. Meyer was later to write that case book notations at Kankakee ‘were records of the trouble and disturbance the patients made for the attendants ... instead of what ailed or troubled the patient’.⁷⁸

Kankakee’s physicians, notes Lamb, were deprived of the neurological education that Meyer had received in Germany, and were unable to correlate the specific lesions and pathological tissues which he was identifying under the microscope with any detailed knowledge of brain anatomy. The organisational disarray of patient records, combined

staunch supporter of the social hygiene movement. The Nancy school, which was centrally based in France, was brought about through the works of Amboise-Auguste Liebeault in 1866, and although they used the method of hypnosis, they were largely antagonistic to Charcot and the Parisian school, which centered on the study of hysteria. See Konrad Akert ‘August Forel – Cofounder of the Neuron Theory (1848-1931)’ *Brain Pathology* 2 (1993) 425-430 pp. 425-26, 428.

⁷⁶ Adolf Meyer in *The Commonsense Psychiatry of Adolf Meyer: Fifty-Two Selected Papers Edited, with a Bibliographical Narrative* ed. Alfred Lief (New York: McGraw Hill, 1948) p. 19.

⁷⁷ Lamb ‘Pathologist of the Mind’ p. 43-60.

⁷⁸ Meyer ‘My Experience with American Psychiatry’ (1898) quoted in Lamb, ‘Pathologist of the Mind’ p. 47.

with the ‘absence of any systematic record of the patient’s symptoms while they were alive’, meant that Meyer’s pathological work could have little effect upon patient care or treatment.⁷⁹ The hospital’s director recognised this deficit in his staff; and, in an attempt to bring the hospital more in line with modern scientific methods, Meyer was instructed to carry out a series of in-house lectures on brain anatomy.⁸⁰ In time, these neurological lectures broadened out so that individual patients were studied alongside pathological tissues, enabling Meyer to interact with *live* hospital patients. Despite having limited training in the subject of psychiatry, he found that he conversed easily with patients, and in time began to ‘discern clinically relevant data from their narrative utterances and symptomatic behaviours’.⁸¹

Buoyed by his limited success, Meyer read extensively upon experimental psychology, the symptomatology of mental diseases and methods of clinical observation.⁸² Searching for a satisfactory framework ‘from which to demonstrate the relationship between pathological anatomy and psychiatric symptomatology’, Meyer broadened his outlook by reading the works of French clinicians such as Jules Dejerine, as well as Janet on notions of the unconscious mind, hypnosis and suggestion, and psychologists such as William Wundt.⁸³ Moreover, Meyer was inspired by American pragmatism which taught that, to understand the mentalities of the mentally ill, one must first begin to understand the mechanisms of one’s own thoughts, behaviours and emotions.⁸⁴ Intertwining evolutionary theory with a common sense approach to the study of mind, he was influenced by American pragmatist psychologists and philosophers such as John Dewey, who theorised human activity was an ‘endless series of experiments and tests’. An individual’s actions were understood as being shaped by immediate environmental demands, and also by previous experience, so that human action was ‘endlessly reflexive’, constantly evolving and adapting.⁸⁵ As Meyer and Dewey formed a long-lasting friendship at the University of Chicago in 1893, these pragmatist concepts would inspire Meyer to conceive of human behaviour (situated within

⁷⁹ Andrew Scull and Jay Schulkin ‘Psychobiology, Psychiatry and Psychoanalysis: The Intersecting Careers of Adolf Meyer, Phyllis Greenacre and Curt Richter’ *An International Journal for the History of Medicine and Related Sciences* (2009) January 5-31 p. 7.

⁸⁰ Winters ‘Kankakee’ p. 452.

⁸¹ Lamb ‘Pathologist of the Mind’ p. 52.

⁸² *Ibid* p. 53.

⁸³ Adolf Meyer ‘Thirty-five Years of Psychiatry in the United States and Our Present Outlook’ (1928) in *The Collected Papers of Adolf Meyer, Vol II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951), 1951) p. 4.

⁸⁴ Meyer ‘Misconceptions’ p. 172.

⁸⁵ John Dewey ‘The Postulate of Immediate Empiricism’ in *The Influence of Darwin on Philosophy* (New York: Henry Holt, 1910) p. 227.

and shaped by distinct environmental conditions) as experiments of nature, a core philosophical component to his psychobiological theorem in the years to come.⁸⁶

Stood with one foot in the morgue and the other on the hospital ward, Meyer's training in clinical neurology and interest in psychology made it necessary to insist on a more thorough, uniform system of patient case note-taking and examination. Lamb writes that when Meyer confronted his superiors, they 'bristled' at such a challenge to their authority, but he persisted in his efforts to reform hospital care.⁸⁷ Gradually, he instigated a systematic method of history taking and record keeping among Kankakee's asylum staff. Emphasising the need to create a comprehensive record of the patient's 'mental, physical and developmental history', Meyer applied his neurological training to the study of the living patient. In doing so:

Meyer employed the "case history" as a technical and conceptual device to convert ephemeral experience – that of the patient *and* the clinician – into permanent clinical data that could be accumulated, compared, transmitted, evaluated collectively, and expanded.⁸⁸

The emergence of the dynamic case history and staff meeting

It was from within this environment that Meyer first applied the staff meeting in a North American institution. The story of its development, warns Lamb, now verges on the hagiographical, but in essence the story goes that one day, while the hospital's male medical staff were spending their leisure hours in the staff residence, Meyer escorted a newly admitted patient into staff quarters and asked her to take a seat. Meyer then began to conduct an in-depth examination of his patient in front of the staff, and each day Meyer repeated this performance. By employing a stenographer to take notes while he interviewed the patient, the effect made upon both patients and practitioners, recalled Meyer, was 'simply splendid'.⁸⁹ Meyer's singular examination of a patient grew into a collaborative assessment made by the hospital staff. Newly admitted patients were increasingly interviewed in front of the medical team and an accompanying stenographer.

⁸⁶ Lamb 'Pathologist of the Mind' pp. 101-02.

⁸⁷ Ibid p. 56.

⁸⁸ Ibid p. 17.

⁸⁹ Eunice Winters quoted in Lamb 'Pathologist of the Mind' pp. 56-57. Staff meetings of this kind were brought over by Meyer from the Continent, where they were basic to medical training. See also Lamb 'Pathologist of the Mind' p. 67.

This simple act, argued Winters, which was an extremely uncommon event during this period in North America, became the progenitor of the staff meeting approach.⁹⁰

Worcester State Lunatic Asylum

In the intervening years between Kankakee and 1908 when Henderson was to join Meyer in The Pathological Laboratory, New York, Meyer pursued a deeper understanding of the philosophical and scientific principles that would come to form the psychobiological approach. Meyer's interests, which began with laboratory study of neuropathology, were steadily broadening out to the clinical study of patients upon the wards and, by the end of his first year at Kankakee, Meyer wrote to his brother declaring 'the more I can throw myself into the clinical field, the better it will be. That is what offers the most possibilities here and really promises something'.⁹¹

After attending a meeting of the Medico-Psychological Association in 1895, Meyer's skill as a neuro-pathologist was recognised by psychiatrist Edward Cowles, who persuaded Meyer to leave Kankakee and take up residence as the Chief Pathologist at Worcester State Lunatic Asylum. Cowles, who was in the process of introducing 'modern "scientific" methods of practices', was collating a team of pathologists, histologists, physiologists, biochemists and psychiatrists, to integrate laboratory methods to the care and treatment of asylum patients.⁹² Worcester Asylum was closely associated with nearby Clark University, and Meyer was asked to teach medical psychology to Clark students. Setting out on this new career path, a momentous degree of freedom and opportunity was made possible by his new position:

Meyer immediately set out to do what he had attempted at Kankakee – to standardise procedures for examination, history-taking and ongoing clinical observation; to encourage discussion and collaboration among staff regarding cases; and to integrate the data collected at the bedside and that culled from laboratory techniques such as histology and autopsy.⁹³

Drawn to the clinical study of patients, Meyer recognised his lack of specialist training in the area of clinical research. His introduction to the clinical study of living patients had

⁹⁰ Ibid.

⁹¹ Quoted in Eunice Winters 'Adolf Meyer's Two and a Half Years at Kankakee: May 1, 1893-November 1, 1895' *Bulletin of the History of Medicine* 40 (1966) 441-458 p. 454. Meyer to Hermann and Anna Meyer, 20th December 1894.

⁹² Lamb 'Pathologist of the Mind' p. 60-61.

⁹³ Ibid p. 62.

been ‘gleaned by observation alone’ in the lecture halls of Forel, Jackson and Charcot, and he sought out the published works of the eminent German psychiatrist Kraepelin to elucidate some of the more ‘salient points which arose face to face with patients’.⁹⁴ Gripped with ambition and curiosity, Meyer requested, and was granted, a sabbatical period in which to pursue these studies in the psychiatric clinics of Europe, and he spent the summer of 1892 in Kraepelin’s clinic in Heidelberg.⁹⁵

Emil Kraepelin (1856-1926)

Kraepelin, now recognised as the fore-founder of modern day clinical psychiatry, was a towering figure of late-nineteenth and early-twentieth century Western psychiatry.⁹⁶ During his early career, Kraepelin devised methods for recording patient cases that revolutionised not only psychiatric classifications of mental disorder, but transformed the practice of compiling case note records.⁹⁷ Kraepelin retained the overarching premise that insanity was at bedrock a somatic disorder, but he shifted earlier emphases from neuroanatomy and neuropathology to the ‘careful clinical observation, evaluation ... classification and phenomenological description of mental disorders’.⁹⁸ Highly influenced by the experimental laboratory research of the psychologist Wundt, Kraepelin set up model laboratories in affiliation with the University of Munich where he combined neurological research with the clinical observation of psychiatric patients.⁹⁹ Tracing the longitudinal development of mental and physical symptoms across patients’ life histories, he demonstrated, in multiple editions of his text-book, *Psychiatrie: Ein kurzes Lehrbuch*,¹⁰⁰ how the close observation and collation of hundreds of patient case histories enabled practitioners to look beneath the surface symptom picture and to base diagnosis upon patterns of aetiology, course and outcome.¹⁰¹

Reflecting upon the work of Kraepelin two years after his return from the clinic, Meyer recalled that at, ‘a time when others thought they could get at the nature of disease by

⁹⁴ Lief *The Commonsense Psychiatry of Adolf Meyer* p. 82.

⁹⁵ Lamb ‘Pathologist of the Mind’ p. 62.

⁹⁶ Kraepelin’s influence is strongly felt within today’s biomedical classificatory models as exemplified with DSM and ICD classificatory systems. (Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases).

⁹⁷ Shirley A. Martin ‘Between Kraepelin and Freud: the Integrative Psychiatry of August Hoch’ *History of Psychiatry* 18 (2007) 275-298 p. 278.

⁹⁸ Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ p. 393.

⁹⁹ Herbert Weiner ‘The Concept of Psychosomatic Medicine’ *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 498.

¹⁰⁰ Emil Kraepelin *Psychiatrie: Ein Kurzes Lehrbuch für Studierende und Aertz* 4th edition (Leipzig: Ambr, Abel, 1893).

¹⁰¹ Martin ‘Between Kraepelin and Freud’ p. 278.

arduous section-cutting and microscopy[,] ... Kraepelin reali[s]ed that the great need was a careful sifting of the symptoms of the disease'.¹⁰² It was from this methodological approach that Kraepelin established his seminal differential diagnosis of the most common psychoses into two groups, being dementia praecox and manic-depressive insanity. The disease courses of manic-depressive insanity was recognised to exhibit finite periods of elation and despair or agitation, often punctuated by lengthy remissions, while dementia praecox, which initially presented a similar symptom picture, was typified by a 'predictable decline and irrevocability'.¹⁰³ However, it was the stark division, made by Kraepelin, between dementia praecox (incurable) and manic-depressive insanity (curable) that Meyer considered too deterministic.¹⁰⁴ Regarding Kraepelin's methodology too heavily focused on the collation of symptoms and the compilation of diagnoses, Meyer was to advocate the:

[I]deal was not to make classification the aim but only a means to keep order. The chief aim was to go as far as possible at the study of the facts in each case, and to put the emphasis on the living patient and the problems of determination of his condition, the causes, and remedial measures.¹⁰⁵

A science of the individual

Over the next six years Meyer built up a collection of detailed case histories, which emulated Kraepelin's own method of creating a catalogue of 'specimen[s]' through which to chart and cross-reference his clinical findings.¹⁰⁶ Determined to replicate the high clinical standards of observation and history-taking demonstrated by Kraepelin, he pursued his own research into the 'pathological processes responsible for various forms of mental disorder'.¹⁰⁷ Acquiring four new assistants, Meyer taught them clinical techniques of record keeping and examination; and, as they accompanied Meyer to the bedside of patients, they learned how to take down in shorthand Meyer's examinatory questions and patients' responses. Lastly, Meyer organised daily staff meetings, where he, the Physician-

¹⁰² Adolf Meyer 'A Few Trends in Modern Psychiatry' in *The Collected Papers of Adolf Meyer, Vol II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) pp. 389-90.

¹⁰³ Stanley W. Jackson 'A History of Melancholia and Depression' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 449. See also Lamb 'Pathologist of the Mind' p. 63.

¹⁰⁴ Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 335.

¹⁰⁵ Adolf Meyer 'Organization of the Medical Work in the Worcester State Hospital' in *The Collected Papers of Adolf Meyer, Vol II, Psychiatry* (first published in 1914 in *Transactions of the American Medico-Psychological Association*) (Baltimore: The Johns Hopkins University Press, 1951) p. 59.

¹⁰⁶ Lamb 'Pathologist of the Mind' p. 69.

¹⁰⁷ *Ibid* p. 65.

Superintendent and his assistants discussed newly admitted cases and the general state of affairs on the wards.¹⁰⁸

‘[H]ere you have a patient’, Meyer addressed his students and colleagues, ‘reacting to a set of concrete environmental conditions: ones which usually would not have upset you or me, but which upset the patient ... Now what makes the difference between [the patient] and you and me?’ The difference, taught Meyer, may be constitutional, may be environmental, or may be both; and, to ascertain the precise nature of the precipitating factors, the practitioner must look to the ‘facts of the history’.¹⁰⁹ ‘Every step’ in the life history of the patient was considered by Meyer as ‘an experiment telling us the story, and giving us the concrete facts to be minded’.¹¹⁰ It was the patients’ history of adaptation that Meyer most heavily valued, as both an ‘investigational and therapeutic tool’.¹¹¹ Once patients’ stories became set within the confines of the mental hospital, Meyer continued to capture their trajectory, so that their symptoms could be understood as reactions set within, and reacting to, the clinical environment.¹¹² The purpose of the case note record was to capture not only the ‘momentary statements and reactions’ evidenced by patients within a ‘detached examination’, but also, as Meyer moved around the hospital, often followed by his note taking assistants and stenographers, repeated interviews with patients were compiled so that case records read ‘like a continuous, consistent story’, documenting the ‘evolution of the complex, the time and duration of circumstances of its development ...’.¹¹³ It was therefore within such a conceptual sphere, that Meyer was to replace the concept of mental disease with the concept of reaction types ‘that required both physical and psychological explanation’.¹¹⁴

Pathological Laboratory of the New York State Hospitals, 1902-1911

By the time that Meyer had been appointed Director of the Pathological Laboratory of the New York State Hospitals in 1902, a post combined with the professorship of Psychiatry at

¹⁰⁸ Ibid p. 67. See also Gerald Grob *Mental Illness and American Society 1875-1940* (Princeton: Princeton University Press, 1983) pp. 294-98.

¹⁰⁹ Adolf Meyer ‘The Role of the Mental Factors in Psychiatry’ *American Journal of Insanity* LXV (1908) 39-52. Reprinted in *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) pp. 581-83. See also Lamb *Pathologist of the Mind* pp. 179-81.

¹¹⁰ Ibid.

¹¹¹ Lamb ‘Pathologist of the Mind’ p. 12.

¹¹² Adolf Meyer ‘Outlines of Examinations’ in eds. Eunice Winters, *The Collected Papers of Adolf Meyer, Volume III, Medical Teaching* (Baltimore: The Johns Hopkins Press, 1951), p. 237-38.

¹¹³ Lamb ‘Pathologist of the Mind’ pp. 201-202.

¹¹⁴ Double ‘Adolf Meyer’s Psychobiology and the Challenge for Biomedicine’ p. 390.

Cornell University, Meyer had united his neuropathological work with teaching duties that were primarily concerned with psychology and psychiatry.¹¹⁵ The Pathological Laboratory, which was located in isolation from the care and treatment of patients in the Metropolitan Life Insurance Building, One Madison Avenue, was immediately relocated by Meyer in 1902 to a disused bakehouse in the basement of the Manhattan State Mental Hospital, situated on Wards Island.¹¹⁶ Bringing laboratory research into closer relations with clinical work upon the wards, Meyer, with the help of his wife (formerly Miss Mary Potter Brooks) next set about introducing a systematised routine of occupation and recreation for patients on the ward.¹¹⁷ In 1909 a Miss Wright, trained in ‘play and occupation for nurses’, introduced an early form of occupational therapy to the Mental Hospital. ‘Groups of patients’ recalled Meyer in 1921 ‘with raffia and basket work, or with various kinds of handiwork and weaving and bookbinding and metal and leather work, took the place of the bored wall flowers and of mischief-makers’.¹¹⁸

Set to redirect the focus of pathological research, so that researchers moved between the morgue and living patients, Meyer summed up the application of his methods in his annual report of the Pathological Laboratory (renamed by 1909 as the Psychiatric Institute of the New York State Hospitals). Arguing the aim of the institution was to create ‘a system of standards’, these standards foremostly consisted of Meyer’s uniform case note taking techniques and of the staff meeting:

The Institute was not to be a sideshow such as so many pathologists in State institutions have been forced to maintain ... it was to create standards ... to establish a ... sane view of specific problems, rather than introduce uncritically the fads and methods of other departments of medicine ... The plans and methods of examination of the patients, the standard of accuracy about the facts of the development of the disorder as well as about the actual nature of the disorder ... [and] the system of control by staff meetings, these are matters on which a safe and profitable routine is established in all our hospitals ... history taking, the physical and mental examination of patients, have been imbued with a never failing interest.¹¹⁹

¹¹⁵ Lamb ‘Pathologist of the Mind’ p. 71.

¹¹⁶ Ibid.

¹¹⁷ Thomas A. C. Rennie ‘Adolf Meyer (1866-1950)’ *Psychosomatic Medicine* 12 (1950) 2 71-72 p. 72. See also Adolf Meyer ‘Philosophy of Occupational Therapy’ *Archives of Occupational Therapy* 1,1 (1922) p. 3.

¹¹⁸ Meyer ‘Philosophy of Occupational Therapy’ p. 3.

¹¹⁹ Adolf Meyer ‘Report of the Psychiatric Institute of New York State Hospitals *Annual Report of State Commission in Lunacy* 21, 96-106, quoted in Gelder ‘Adolf Meyer and His Influence on British Psychiatry’ p. 424.

By teaching his colleagues and students the specific institutional practices by which cases were to be examined and recorded, Meyer standardised the medical examination so that it could be carried out in a ‘uniform and systemic fashion’. As Leys writes, ‘[h]e provided his students with a basic outline to be followed, specifying the order of procedure ... and ... actual questions to be put to the patient, something that had been lacking in previous handbooks of psychiatry’.¹²⁰ By placing such emphasis upon the correct and systematic compilation of clinical records, case note taking became the administrative device that pulled together the strings of the establishment, as the examination of patients, staff conferences, laboratory testing, teaching and treatment were each bound, and integrally shaped, by Meyer’s history taking methods. Guided by the founding principle of evolutionary theory, Meyer passed on an evolving sense of psychobiology; one which conceived the study of mental illness as the study of humanity, constantly engaged in the biological struggle of adaptation.¹²¹ To such scientific principles, Meyer combined the philosophical ideals of American pragmatism by highlighting the importance of observing ‘our *own* mental activity *and* that of others in practical life’. Arguing that it was often the patient’s faulty *reactions* to their environment, rather than the possession of a distinct disease or disorder, which constituted mental illness, these reactions were, for Meyer, the pivotal point of exploration in each case.¹²² The patient’s immediate experiences ‘as observed by the physician and elicited in conversation with the patient’ were the essential ‘facts’ to be recorded, using the ordinary or “commonsense” language of everyday life’.¹²³

Meyer, Henderson, and the Pathological Laboratory of the New York State Hospitals, 1908-1911

In 1908 Henderson became part of the laboratory’s specialised research team, and he and the other Laboratory staff assisted Meyer to carry out neuropathological and clinical research upon some of the 4,500 patients housed in the mental hospital. It was during this time that Henderson was first introduced to the staff meeting. Conducted under the chairmanship of Dr. George H. Kirby, Meyer’s former senior clinical assistant, and the then clinical director of the Manhattan State Hospital (who would later publish Meyer’s outlines for mental examination and history taking), Henderson found the staff meeting a ‘magnificent training system for the junior members of the staff, not only because of the

¹²⁰ Leys *Types of One* p. 5-6.

¹²¹ Lamb ‘Pathologist of the Mind’ p. 92.

¹²² *Ibid* p. 12.

¹²³ Leys ‘Types of One’ p. 5.

wealth of clinical material but also because of the careful and skilled manner in which it was discussed by the more senior members of staff'.¹²⁴

Reunited with Campbell, Henderson spent his first year on a female ward of the mental hospital, studying a variety of affective disorders such as schizophrenia, paranoid states, psychopathic states and a number of psychoneurotic patients. He recalled that he learned the art of history-taking, of studying the 'causation, clinical manifestations, the possibilities of prevention, and methods of treatment', as Meyer's 'system of standards' was vigorously enforced.¹²⁵ By 1909, Henderson's responsibilities within the Institute increased as he was promoted from intern to a junior physician, being placed in charge of a ward containing 50-60 patients, all of whom suffered from organic diseases of the central nervous system. The majority of these patients were syphilitic, and such a ward, recalled Henderson, was an 'eye opener'. Many patients lay emaciated, suffering from bedsores and unable to perform the most basic of physical and mental processes. As the London pathologist Mott wrote of such wards in 1910:

... there is nothing more pitiable or degrading than ... these wrecks of humanity sitting in a row, their heads on their breasts, grinding their teeth, saliva running out the angles of the mouth, oblivious to their surroundings, with expressionless faces and cold, livid, immobile hands.¹²⁶

The sights, sounds, smells and the sheer hopelessness of such cases would undoubtedly have demanded a great degree of emotional discipline on the part of Henderson, and yet, with the perspective of hindsight, Henderson reflected, '[fr]om the point of view of clinical work', it was a 'splendid harvest' of neurological and psychiatric syndromes. Henderson learned to examine how disorders of memory, speech, emotion and the formation of ideas correlated with physical signs of disease. 'We were taught', wrote Henderson, how to be 'good clinical observers, to take careful chronological case histories, to study personalities, to analyse symptoms, and to correlate our findings with aetiological agents'. When death and autopsy claimed patient's emaciated bodies, their investigations continued with the pathological examination.¹²⁷

¹²⁴ Henderson *The Evolution of Psychiatry in Scotland* p. 160.

¹²⁵ Ibid.

¹²⁶ Scull *The Insanity of Place/ The Place of Insanity* p. 199.

¹²⁷ Henderson *The Evolution of Psychiatry in Scotland* pp. 163, 165.

Between 1908 and 1911 Henderson was anxious to broaden his outlook and read extensively the works of Freud, Jung and the psychoanalytic schools, while studying the wider psychobiological principles of Meyer. At this time Meyer considered psychoanalysis compatible with the aims of psychobiology and, after Freud and Jung were welcomed to Wards Island to give a series of lectures at Clark University, psychoanalysis was discussed with great interest during the following months.¹²⁸ Within staff meetings psychoanalytic concepts were readily reviewed and a number of papers, Henderson later recalled, were read out at the Wards Island Psychiatric Society, the most notable being Meyer's paper on 'A Discussion of Some Fundamental Issues in Freud's Psycho-Analysis' and Campbell's translation of Ferenczi's paper 'On Habit-Neuroses and Psycho-neuroses in the Light of Freud's Investigations and on Psycho-analysis'.¹²⁹

It was during the discussion of Meyer's paper on 'Freud's Psycho-Analysis' that the sexual theories of Freud and the role of dream analysis were given pre-eminence. Dreams, stated Meyer, were, according to Freud, given to 'express much more directly and uncritically the trend and bend of our imagination than anything we expose in our more circumspect wake-thought'.¹³⁰ In agreement with Freud, Meyer recognised the aetiological role played by the suppression and displaced discharge of desires and longings.¹³¹ Dreams, he concurred, *could* be analysed through the use of psychoanalytic techniques to begin to unveil the 'mental working of a person', but the 'remarkable thing' about dreams, warned Meyer, 'is the peculiar process of distortion and condensation or transposition and symboli[s]ation of the material'. He regarded Freud as a 'detective', whose ability to 'unravel' the 'strings of events' that lurked within the dream, and to decode the vast and seemingly disconnected symptoms of the neuroses, was quite exceptional. He nonetheless postulated:

It is quite obvious that the whole method can easily be attacked and also discredited by the uncritical use by imaginative and self-sufficient workers... Not everyone is born a detective. Not everybody can venture upon the ground of rather delicate constructions and interpretations.¹³²

¹²⁸ Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 335.

¹²⁹ Henderson *The Evolution of Psychiatry in Scotland*.

¹³⁰ Adolf Meyer 'A Discussion of some Fundamental Issues in Freud's Psychoanalysis' *State Hospital's Bulletin New Series 2* (1909-1910) 827-848. Reprinted in *The Collected Papers of Adolf Meyer Volume II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) p. 616.

¹³¹ Meyer 'A Discussion of Some Fundamental Issues in Freud's Psychoanalysis' p. 606.

¹³² *Ibid* p. 617.

As the following decade progressed, Meyer's admiration of Freud waned. He became increasingly opposed to the specialised language used by psychoanalytic followers, which conflicted with his own insistence upon the use of common-sense language in the production of case note records. Moreover, Meyer insisted that psychiatrists resist embedding patient life histories within narratives that focused upon 'sexual desire, repressed conflict, and compensatory fantasy', which were so integral to Freudian analysis.¹³³ As Leys make clear, Meyer developed methods of conducting and recording psychiatric examinations so that the "'positive" facts' of the case, such as the patient's verbally expressed 'wishes, desires and emotions' stood 'above or in implicit precedence to any particular interpretation'.¹³⁴ '[I]n formulating the experiment of nature' Meyer wrote in 1908:

The most essential achievement is not the erection of a word-palace of logic or of description, but the enlargement of our command of action, however modest.¹³⁵

The case note record was conceived to form 'a body of knowledge on which all fair-minded investigators must agree'.¹³⁶ With Meyer's forewarning in mind, Henderson and his colleagues adapted the methods of Freud and Jung, so that they became familiar with, but not wholly aligned to, the 'technique[s] of dream analysis and of word association tests,' while appreciating 'the validity of mental mechanisms concerned with projection, transference, displacement of affect, and symbolism'.¹³⁷ Freud's conceptualisation of the dynamic unconscious, and the stress laid upon 'socio-psychic conflict', became a highly debated topic of conversation at staff meetings, and Henderson evidently flourished within such a fertile intellectual community.

Constitution, classification and personality studies

With both the 'psychological as well as physiological' aetiologies of mental illness taken into account, Meyer was, by this period, writing more confidently upon his delineation of

¹³³ Ruth Leys 'Types of One: Adolf Meyer's Life Chart and the Representation of Individuality' *Representations* 34 (1991) 1-28 p. 6.

¹³⁴ *Ibid* p. 6.

¹³⁵ Adolf Meyer 'The Problems of Mental Reaction-Types, Mental Causes and Diseases' *The Psychological Bulletin* 8 (August 1908) 245-61 p. 252.

¹³⁶ Leys 'Types of One' p. 6.

¹³⁷ Henderson *The Evolution of Psychiatry in Scotland* pp. 188-89 see also Digby Tantam 'Fairbairn' *150 Years of British Psychiatry Volume II: The Aftermath* (London and Atlantic Highlands: Athlone Press, 1996) p. 555.

'reaction types' rather than 'diagnoses',¹³⁸ whereby 'a psychosis was looked upon in terms of situation, reaction, and final adjustment'.¹³⁹ As Meyer studied the reactions of individuals to their 'total social and physical environment',¹⁴⁰ he began to filter their complex life histories, picking out the faulty habits of reaction that characterised their case; comparing, contrasting and subsequently grouping his patients into distinct 'reaction types'.¹⁴¹ Studies of 'constitution', 'personality' and 'characterology' became a predominant feature of Meyer's research and publications, as he undertook to distinguish mental disorders that stemmed from a 'definite illness' (disease, infection) or exogenous environmental factor, from those which originated, at least in part, from an underlying 'constitutional defect' that lessened the 'efficiency' of an individual's 'mental adaptations'. Writing as early as 1903, Meyer stated:

The purpose of characterology is to give a forecast of what a person would do in a considerable variety of emergencies. As alienists, we shall especially have to try and find out whether persons show any combinations of reactions which would make them in our eyes candidates for mental derangement ...¹⁴²

By 1910 Meyer left New York to take up practice as the Professor of Psychiatry at The Johns Hopkins University, Baltimore, where he subsequently became Director of the Henry Phipps Psychiatric Clinic upon its opening in 1913. Hoch, 'a fellow Swiss', took over the running of the then renamed Psychiatric Institute and it was under his leadership that Henderson became engrossed in studies of 'personality'.¹⁴³ In the years leading up to

¹³⁸ Meyer 'The Problems of Mental Reaction-Types' p. 257.

¹³⁹ D. K. Henderson 'Catatonia as a Type of Mental Reaction' *British Journal of Psychiatry* 62 (1916) 556-572 p. 558.

¹⁴⁰ Leys 'Types of One' pp. 2-3.

¹⁴¹ In a 1903 paper Meyer explicates his method by stating: 'We shall try to distinguish certain groups; but we must submit all these cases to the question: Do we deal with persons in whom some incidental affection of the brain or malnutrition during development or constitutional disturbances, like rickets, or poor educational condition, has produced that state of affairs which has left scars or residuals and stamps the person as one maimed in various directions ... and for such reasons left with an inadequate material for development and the strain of life? Or do we deal with persons whom ... there are present and still in operation various vitiating influences, such as disease, anomalies of constitutional metabolism, abnormal toxic or sexual habits, an inadequate and unsatisfying life, etc.?' Adolf Meyer 'An Attempt at Analysis of the Neurotic Constitution' *The American Journal of Psychology* 14 (Jul-Oct 1903) 90-103 pp. 360-361. See also Meyer 'The Problems of Mental Reaction-Types'.

¹⁴² Meyer 'An Attempt at Analysis of the Neurotic Constitution' pp. 356-58.

¹⁴³ Concepts of personality do, of course, stem back to earlier philosophical, cultural and psychiatric formulations of the individual self. The work of Janet, for example, upon cases reclassified as neuroses, highlighted a small proportion of patients evidencing the possession of 'multiple personalities'. Building upon the work of practitioners such as Louis Vibe, Henri Bourru and P. Burot, Janet's hysterical patients were seen to possess two or more distinct personalities. This led Janet to formulate the theory of 'subconscious mental activity', as he held that the mind simultaneously functioned upon two levels of cognition, being that of the 'conscious' and 'subconscious' spheres. Out of this research the idea of a dynamic subconscious emerged, as Janet proposed that memories of traumatic events could become

the eve of the First World War, psychiatrists Hoch and George S. Amsden cemented Meyer's studies on reaction-types within a set of publications that made personality studies one of the cornerstones of dynamic psychiatry. By integrating and adapting the clinical methods of Kraepelin, the 'reaction-type' diagnostic philosophies of Meyer, and the psychoanalytic theorems of Freud and Jung, Hoch began to theorise that the 'dramatic symptoms' seen in clinical studies of diagnoses such as dementia praecox were often 'accentuations of the individual's pre-existing personality traits', thrown into sharp relief in the wake of some traumatic event.¹⁴⁴ In 1910 Hoch published his studies into the dementia praecox personality type.¹⁴⁵ Concurring with Meyer that mental disorders were 'largely faulty habits of adjustment', Hoch encouraged his colleagues to judge how the 'original make-up, constitution or personality of the individual' coloured the symptom picture. In doing so, it enabled psychiatrists to build up a picture of the patient's 'likes and dislikes, hopes and fears' so that they could be guided down the path of recovery recognised as being most suited to their individual disposition.¹⁴⁶

It was during this time that Henderson began to publish his clinical findings, and in 1911 he authored an article on 'The Diagnosis of Cerebral Syphilis' published in the *Review of*

embedded within the subconscious, which in turn could insidiously act upon the thoughts and actions of the individual beyond their conscious control. The key to therapeutic success was thereby seen to lie with the practitioner's ability to access, and thereby alter such insidious thoughts, and it is through this approach that research into subconscious mental activity flourished within the work of Breuer and Freud in Vienna, William James and Morton Prince in America, and Frederick Myers in Britain. The role played by Breuer in the formation for psychoanalytic conceptualisations of personality is of especial significance. Famed for his work in the 1880s on hysteria and the case of his patient named 'Anna O.', Breuer observed that by encouraging his patient to give voice to a series of traumatic events that were buried deep within her 'unconscious mind', the symptoms of her illness dissipated. Breuer theorised that traumatic memories, which were inadmissible to the conscious mind, became buried within the 'unconscious', but that through the act of storytelling, Freud wrote that his colleague's 'psychotherapy brought the operative force of the idea to an end. By allowing the patient to release its "strangled affect" through speech ... the forbidden idea [was brought] into consciousness'. Like Janet, Breuer spoke of a dynamic unconscious, but unlike Janet, Breuer theorised that the splitting of mind, evidenced in hysterical patients, 'is present in all human beings—both the healthy and the ill'. See Gach 'Biological Psychiatry in the Nineteenth and Twentieth Centuries' p. 390. Adam Crabtree 'The Transition to Secular Psychotherapy' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008) p. 575. Edward M. Brown 'Neurology's Influence on American Psychiatry: 1865-1915' in *History of Psychiatry and Medical Psychology* eds. Edwin R. Wallace and John Gach (New York: Springer, 2008). Philipp Gudmann 'Julius Ludwig Koch (1841-1908): Christian, Philosopher and Psychiatrist' *History of Psychiatry* 19, 2, (2008) 202-214.

¹⁴⁴ Theodore Millon *Disorders of Personality: Introducing DSM/ICD Spectrum from Normal to Abnormal* (Canada and New Jersey: John Wiley and Sons, 2011) p. 665.

¹⁴⁵ Martin 'Between Kraepelin and Freud' p. 284.

¹⁴⁶ Martin 'Between Kraepelin and Freud' p. 283. See also D. K. Henderson and R. D. Gillespie *A Text-Book of Psychiatry* (London: Oxford University Press, 1962) p. 90.

Neurology and Psychiatry.¹⁴⁷ Integrating the teachings of his colleagues with his own observations of syphilitic patients, Henderson gave a detailed portrayal of the acute onset of ‘headaches, dizziness, vomiting, sleeplessness, cranial nerve palsies ... and hemiplegia’ seen to characterise this diagnosis.¹⁴⁸ This publication was followed the same year by ‘*Tabes Dorsalis and Mental Disease*’, in which Henderson showed a confident allegiance to research emanating from the Pathological Laboratory. At a time when the majority of psychiatrists and neurologists expressed the belief that tabes and G.P.I. (General Paralysis of the Insane stemming from syphilitic infection) were essentially the same disease, Henderson rejected this idea, publically claiming that although in the ‘majority’ of tabes dorsalis cases symptomatology ‘evidence ... the onset of general paralysis’, autopsy revealed ‘a certain number of cases ... [where] the cortical changes of general paralysis are absent’.¹⁴⁹

By 1911, after several years spent in New York, Henderson decided to embark upon more specialised training. He later reflected that he was ‘filled’ with the ‘confidence born of the effrontery of youth’ and applied to Kraepelin and to Alzheimer, of the ‘world famous’ Psychiatric Clinic, Nussbaumstrasse in Munich, for a place on the postgraduate autumn course. His applications were duly accepted, and Henderson began his preparations to leave New York. Before his final departure, however, he made a trip down to Baltimore to visit Meyer. While in Baltimore, Meyer offered Henderson a post at the new Henry Phipps Psychiatric Clinic, due to be opened the next year. The offer was formally received with appreciation (see below) and yet, as he wrote in reply to Meyer, the urge to begin to return to Scottish soil and, as Campbell had stated several years previously, to do practical work there, persuaded him to decline the offer. Like Campbell before him, his appetite for knowledge pushed him towards the great psychiatric clinics of Germany, and he once again set sail for a new and promising land.

¹⁴⁷ D. K. Henderson ‘The Diagnosis of Cerebral Syphilis’ *Review of Neurology and Psychiatry* 9 (1911) 241-51. A review of his article appears in 1911, see C. E. Atwood ‘Review of Neurology and Psychiatry (IX No. 5. 1911)’ *Journal of Nervous and Mental Disease* 30 Nov (1911) 11 701-02.

¹⁴⁸ Davis *The Cruel Madness of Love* p. 105.

¹⁴⁹ D. K. Henderson ‘*Tabes Dorsalis and Mental Disease*’ *Review of Neurology and Psychiatry* 9 (1911) 527-45 p. 530.

Wards Island
New York

May 4th 1911

Dear Dr Meyer

Ever since leaving Baltimore I have been carefully considering the proposal which you were so kind as to make to me. I realise perfectly well the ideal conditions that will shortly exist at Baltimore for psychiatric work, and know that I would be extremely benefited by working there in more ways than one, but I have determined to try my fortune in Scotland. I may be rash – and probably am – to decline such a good opportunity as you offered me but the way I feel about things is that the longer I stay away from Scotland the more difficult will it become ever to get back. I also feel that it is to a certain extent the duty of those of us who have had the good fortune to receive a pretty thorough training in Psychiatry to try to do what we can – even although it is very little – to help things onto a better footing because otherwise I don't see how things can possibly change as the men at home don't seem to in the slightest degree realise where the defects in their system are. Whether they will ever admit that their system has defects is of course quite another question which can only be settled in the course of time. It is for these reasons, and also for certain sentimental reasons that I keenly regret that I am unable to accept your offer.

You may remember when I was in Baltimore I mentioned that Dr Maloney who held a Crichton Research Scholarship had resigned it or was about to do so.

I intend to send in an application for the position some time soon, and as, according to our ancient customs, applicants require to send with their applications copies of testimonials from the various men with whom they have worked, I would appreciate it very much if you could favour me with a testimonial.

It seems rather a peculiar kind of gratitude for many kindnesses received first of all to decline a position, and then to ask for a testimonial for another one but I daresay you appreciate my reasons.

With kindest regards to Mrs Meyer and yourself, and with many thanks for your kindness and encouragement.

Believe me

Very sincerely yours

David K. Henderson

P.S The Crichton Research Scholarship for which I am sending in an application is in Clinical Neurology and Psychology¹⁵⁰

Munich, Edinburgh and London, 1911-1912

Sailing up the river Elbe into the port of Hamburg, Henderson arrived in Germany with several months to prepare his language skills before enrolling in Kraepelin's autumn course. This time was spent in the village of Bad Sacha at the foothills of the Harz

¹⁵⁰ Individual Correspondence Henderson, Dated 4th May 1911 Box no I/1659/1 AMC.

mountains, where Henderson progressed from reading Grimm's Fairy Tales to a slow translation of Kraepelin's text-book of psychiatry. Once the summer had passed, Henderson moved to a small, cold garret room within the city of Munich to begin his postgraduate studies.¹⁵¹

First meeting with Alzheimer, one of the great twentieth-century leaders of neurology, Henderson was later to describe him as the most dominating personality at the Nussbaumstrasse Clinic. Over six feet in height, he bore down over his colleagues. Portrayed as a man of 'magnificent physique ... very dignified', his face bore the scars of sabre cuts, accumulated in his student days.¹⁵² As Henderson had formerly applied himself to the study of acute organic reaction types within New York, so many of which had lain in the syphilitic ward, he furthered this interest when under the tuition of Alzheimer through the microscopic study of the 'cerebro-spinal fluids' of syphilitic patients. Alongside pathological studies, Henderson poured over the case reports produced by Alzheimer of the premature senile state that he eponymously named Alzheimer's disease, and it was from these case reports that Henderson learned to correlate the outward signs of the degenerative condition with post-mortem examination of the brain. The 'perplexed, stupid and confused' manner which many displayed, wrote Henderson, when assessed alongside their disorientated grasp of time and place, signified the underlying state of the brain's cortical cells where 'only a tangled bundle of fibrils remained'.¹⁵³ Henderson connected his practical skills on the ward - garnered from his observation and interaction with living patients - to chemical analysis and post-mortem examination, and through such a process his dynamic approach to psychiatry increasingly took form. In a letter written to Meyer after a month's instruction, Henderson noted:

I have been working in Alzheimer's laboratory ever since coming here 5 weeks ago. He spends a long time in the laboratory every day, comes round to each one individually, and is very instructive, and very genial. I like him very much.¹⁵⁴

This letter continued to state, that, while inspired and enlightened by Alzheimer's teachings, he was also in many ways critical of his Germanic lecturers. In *The Evolution* Henderson described Kraepelin as a formidable, thick set and intensely serious man, whose world-renowned leadership in the field of psychiatry was substantiated through his

¹⁵¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 170-71.

¹⁵² *Ibid* p. 172.

¹⁵³ *Ibid*.

¹⁵⁴ Individual Correspondence Henderson, Dated 29th October 1911, Box I/1659/I AMC.

comprehensive lecture series.¹⁵⁵ Nonetheless, Henderson privately conceded in his letter to Meyer that there was a lack of empathy shown in Kraepelin's lectures, and a disinterest in the patient's individual personality and former constitution, which he found troubling.¹⁵⁶

Pension Lampect
Schonfeldstape, 21
Munchen
October 29th 1911

Dear Dr Meyer

Just a line or two to let you know how things are going on here. I have just had the first week of the post-graduate course, and have found it both interesting and disappointing. Kraepelin's clinics are extremely good in their way. He presents the cases very concisely but in a very cut-and-dried way, and seems to base his diagnosis almost entirely on the symptom picture. Very little weight seems to be laid on the previous constitution of the individual, and even a slight analysis does not seem to be attempted. The case histories which I have seen are ... not nearly so good as the average at Wards Island ...¹⁵⁷

Kraepelin, as Henderson wrote in 1927, was, of this period, the outstanding exponent of the symptomatological classification of mental illness. After building up his detailed collection of patient case histories which numbered into the thousands, Kraepelin's classificatory system was founded, not only on a cross-sectional analysis of his patient's symptoms, but also on longitudinal studies which charted the onset and the full duration of a patient's case.¹⁵⁸ Like Meyer before him, these studies evidently impressed Henderson, as he acknowledged Kraepelin in his 1927 *Text-book* as enabling the psychiatrist to look past the temporary symptom picture, to identify the fundamental underlying disease through the compilation of case studies.¹⁵⁹ Yet, as Meyerian case histories sought not only to unveil the progression of symptom pictures, but also to relate how the personality of each and every individual patient shaped the prognostic outlook, Kraepelin's lectures seemingly lacked such dynamics.

¹⁵⁵ Henderson *The Evolution of Psychiatry in Scotland* p. 173-174.

¹⁵⁶ The lack of empathy shown by Kraepelin towards schizophrenic patients is later criticised by the Scottish psychiatrist Laing, see Philo and McGeachan 'Words' p. 19.

¹⁵⁷ Ibid.

¹⁵⁸ German E. Berrios, Rogelio Lucue, and Jose Villagran 'Schizophrenia, A Conceptual History' *International Journal of Psychology and Psychotherapy* 3 (2003) 2 111-140 p. 114.

¹⁵⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927).

In the second half of Henderson's letter to Meyer, the following passage demonstrated the failings he saw in those who appropriated the Kraepelinian system. Ernst Rudin, who had trained under Kraepelin and whose research on eugenics and hereditary degeneration was used to detrimental effect under the Nazi regime, presented Henderson's class with the case of a young man whose mental decline was diagnosed as a case of Dementia Simplex. Following the symptomatological diagnostic process of Kraepelin, Rudin presented a highly pessimistic outlook for this patient, suggesting the boy would slowly degenerate, first exhibiting alternating states of depression and excitement, before degenerating further to a state of mental stupor.¹⁶⁰ Such a conclusion was judged by Henderson to be a most incredulous assertion, his scepticism expressed by an abundant use of exclamation marks:

Rudin gives demonstrations of mental disorders in the young, and also lectures on degeneration. He presents his cases in a very similar manner to Kraepelin, and perhaps the best illustration I could give you of his point of view would be to shortly cite the first case he presented. The case was that of a boy, 18 years, who had been backward at school, had always been somewhat incorrigible; later showed some slight criminal tendencies (petty thefts), and never learned any definite trade. When 15 years old the boy was described by his parents as becoming dull, and listless, and apparently more unmanageable. Rudin, therefore, said that the onset was probably of 3 years duration! In the clinic he was quite bright, no disorder in stream of thought, no peculiar ideas demonstrated, and no hallucinations at any time. The case was summed up as one of Dementia Simplex, and the remark was made that he would probably later develop Katatonic features!!!¹⁶¹

Henderson later wrote in the *Text-book* that Kraepelin's definition of dementia praecox held a number of 'principal drawbacks', the most prominent being an attitude of 'therapeutic nihilism' engendered by Kraepelin's deterministic stance towards the outcome of such cases.¹⁶² The simplicity of their method, Meyer wrote in reply to Henderson's letter, was enviable, but Kraepelin and Rudin's reliance on the theory that hereditary and degeneracy were alone the deterministic factors in such cases failed to take into account

¹⁶⁰ The description of the katatonic state is given in Henderson and Gillespie's *Text-Book of Psychiatry* (1927) where such cases are described: 'The usual history is a more or less general statement that there has been a general falling off in interest, an apathy, a lack of concentration, a dreaminess ... Then a state of dull stupor develops, with mutism, refusal of food, and with such a diminution of all activities that the patient may sit idly in one position, with the hands stretched out on the knees, and the head bowed between the shoulders, the whole aspect being that of a [Egyptian] mummy' p. 210.

¹⁶¹ Individual Correspondence Henderson, Dated 29th October 1911, Box I/1659/I, AMC.

¹⁶² Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 184.

environmental influences and the specificities of individual constitution.¹⁶³ By 1911 it was the psychoanalytically informed works of the Swiss psychiatrist Eugen Bleuler that were coming to the forefront of psychiatric research into dementia praecox.¹⁶⁴ It was the patient's disordered relation to the external world that was so central to the theories of Bleuler, and therefore the phenomenological experience of the patient, as well as the organic state of their bodies, became the key point of investigation. As Meyer himself had defined dementia praecox in 1906 not as a degenerative disease, but as the progressive maladaptation of an individual constitutionally predisposed to fail under distinct environmental pressures, Henderson's exposure to psychobiological and psychoanalytic circles would have naturally fuelled his scepticism towards Rudin's rudimentary case presentation.¹⁶⁵

It was at this time that Henderson's eagerness to return to Scotland was about to be realised, for, after applying to Dr George M. Robertson for a post back at the Royal Edinburgh Mental Hospital, his request was granted. In the final paragraph of Henderson's letter to Meyer, Henderson informed his mentor of his future plans, and of the responsibilities that he was to face.

¹⁶³ As Meyer delivered a speech on the subject of dementia praecox before the annual meeting of the British Medical Association in 1906 he stated; 'Every individual is capable of reacting to a wide variety of situations by a limited number of reaction types... In psychiatry the facts occur in very complex combinations, and therefore one-word diagnosis is almost sure to fall short of what is ought to do ... Etiologically, the constitutional make-up counts for a great deal but not in the vague sense of hereditary and degeneracy merely. Quoted in Gelder 'Adolf Meyer and his influence on British psychiatry' p. 422.

¹⁶⁴ Bleuler, a Swiss psychiatrist who came to redefine dementia praecox as schizophrenia was critical of the deterministic stance of Kraepelin as he stated that schizophrenia was; 'A group of psychoses whose course is at times chronic, at times marked by intermittent attacks, and which can stop or retrograde at any stage, but does not permit a full *restitution as integrum*. The disease is characterised by a specific type of thinking, feeling, and relation to the external world that appears nowhere else in this particular fashion'. See Gilman 'Constructing Schizophrenia as a Category of Mental Illness' p. 467.

¹⁶⁵ By the eighth edition of Kraepelin's Text-Book such criticisms were beginning to be taken on board as Kraepelin was paying greater attention to the phenomenological aspects of illness, noting how the thought processes of such patients were often 'derailed', their sentences being characterised by stereotypy and by the conflation of words to create neologisms, and yet he rigidly maintained that these cases occurred in the period of puberty or adolescence and that they culminated in the complete deterioration of the mind.

... I don't know whether you will have heard or not but I am leaving here sooner than I expected. A few weeks ago Dr Robertson offered me a job at Morningside which I have accepted, and accordingly have to start work there in January. I expect to take charge of the men's service at the West House.

With kindest regards to Mrs Meyer, and yourself

Believe me

Very sincerely yours

David K. Henderson¹⁶⁶

Meyer's following reply to Henderson's letter gives an interesting insight into Meyer's growing aversion to the simplicity of Kraepelinian theory. Also intriguing is Meyer's warning of the apathetic response towards asylum reform, which, he feared, would be shown by the 'leading men' of Scottish psychiatry.

Nov. 9th, 1911

Dr D.K. Henderson

Psychiatric Clinic

Munich, GERMANY

My Dear Henderson,

I greatly enjoyed your letter, which reached me yesterday; it made quite an interesting picture of things. In clinical matters the presentation of the case by Rudin no doubt shows the worst side of the method. In some respects I envy them for their clean-cut directness, but at bottom I would have a bad conscience much of the time, and I would not have such equanimity about the dogmatic foundations on which the work is made so much more simple and easy. The gem of the Munich Clinic no doubt is Alzheimer, whom I consider, without hesitation, the leader of psychiatry in Germany. As far as actual solid collectivity is concerned he would I believe take a perfectly fair and sensible view of our conceptions if he were exposed to them as much as to Kraepelin's influence.

The opening in Edinburgh strikes me as most promising, and with your level-head and direct manner you are bound to make an impression, although I am afraid the leading men will indulge in the prayer of the bad boy: "Lord, make me a good boy, but slowly, slowly."¹⁶⁷

¹⁶⁶ Individual Correspondence Henderson, Dated 29th October 1911, Box I/1659/I, AMC.

¹⁶⁷ Individual Correspondence Henderson, Dated 9th November 1911, Box I/1659/I AMC.

The clarity of Kraepelin's views, plus the relative ease of their application, is here seen to contrast with the philosophy of psychobiology, as Meyer accepted the 'inherent uncertainty' of psychiatric practice.¹⁶⁸ As the scope of Henderson's psychobiological training provoked him to problematise the absoluteness of Kraepelinian classification, Meyer no doubt realised the ambivalence and possible aversion held by many established British psychiatrists towards Henderson's critical stance. It was therefore with Meyer's gentle warning in mind that Henderson departed from Munich, and reported for duty in January 1912 at Morningside.

Stepping back onto the wards of West House, all was as he had left it. Except for the succession of Robertson to Clouston's old post as Physician-Superintendent, many of his old colleagues remained.¹⁶⁹ Having returned from Munich, Henderson was invited to give his first university lecture on the subject of dementia praecox, and, after having acquainted Robertson with Meyer's method of carrying out medical staff meetings, Henderson began instructing a number of students to perform these collaborative examinations. Incremental changes in the practice and teaching of mental medicine was introduced through Henderson, but, despite the informal integration of Meyer's staff meetings into the student curriculum, Henderson soon found it impossible to settle back into his old haunts and work under the superintendence of Robertson. Fresh from the Continent and the fertile intellectual grounds of North America, his mind was filled with ambitions that, it appeared, could only be implemented incrementally within his present employment. Meyer's cautions seem to have been warranted, as Henderson's frustration with Scottish psychiatry was sharply voiced in the following letter to Meyer:

March 10th 1912

Dear Dr Meyer,

My short stay in Scotland has already thoroughly convinced me that I am not practically adapted for doing pioneer work, and two or three days ago I told Dr Robertson that I had practically decided to return to America.

I am, therefore, writing this to ask if you can still offer me a position in your clinic.

Dr Robertson wants me to stay for a month or two yet as otherwise he might have some difficulty with his clinics, and I have promised to assist him as far as possible.

¹⁶⁸ Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 333.

¹⁶⁹ George M. Robertson (1864-1932) graduated from the University of Edinburgh, and went on to assist Thomas Clouston in the pathology laboratories of Edinburgh University. In 1892 he became Physician-Superintendent of Perth District Asylum and then of Stirling District Asylum in 1899, before taking up his position in at Morningside in 1908 upon Clouston's retirement. See Davis *The Cruel Madness of Love* p. 55.

I have decided to return not so much because things are absolutely impossible but principally because it would take much longer than I had supposed to make much impression...

With kindest regards to Mrs Meyers and yourself.

Believe me

Very Sincerely yours

David K. Henderson¹⁷⁰

Rejecting the responsibility of carrying out ‘pioneer work’, he finished up his teaching duties in Edinburgh and eagerly awaited a new appointment in the United States.¹⁷¹ Henderson’s request to re-join Meyer was soon accepted as Meyer was engaged in gathering his administrative and medical staff for the new Henry Phipps Psychiatric Clinic, due to open later that year. With several months to wait until he could begin his new employment, Henderson’s desire to further his interest in scientific medicine saw him travel down to London to work in the chemical laboratories of the neuropathologist Mott and the chemist Sydney Mann. In a letter to Meyer, Henderson reported that Mott held a ‘tremendous contempt for British Psychiatry, and now refuses to attend the meetings of the Medico-Psychological Society as he says that they are just pretty much of a mutual admiration [sic]’.¹⁷² Whether or not Henderson publicly aired such an opinion is unclear, but in his private correspondence he had come to reject what he saw as the narrow, exclusive, almost stagnant state of the British psychiatric profession.

Henderson was later to reflect upon this period, specifically on the state of Scottish psychiatry, that the ‘human and scientific interest ... was too often lacking’.¹⁷³ Like Campbell before him, Henderson rallied against the partisan politics and administrative concerns that preoccupied Physician-Superintendents within lunatic asylums and mental hospitals. Situated remotely from centres of neurological, biochemical and genetic research, the contrast between British and Germanic psychiatry led him to the realisation that, without power and influence, little could be done to integrate British psychiatry

¹⁷⁰ Individual Correspondence Henderson, Dated 10th March 1912, Box I/1659/I AMC.

¹⁷¹ In an anonymous article in the *Journal of Mental Science* 1914 entitled ‘Report of the Committee re State of British Psychiatry and of Medical Officers’ The sentiments expressed within Henderson’s letter reflect those of a number of his contemporaries, as an undercurrent of disgruntlement was being voiced which described the state of ‘British Psychiatry as ‘a branch of medicine ... in a decidedly inferior position to practically every other branch in the lack of educational facilities, and in the absence of any career for those who desire to undertake scientific work in it ... the work assigned to Junior Medical Officers is in the majority of cases monotonous, uninteresting, and without adequate responsibility [which] leads to the stunting of ambition and a gradual loss of interest in scientific medicine’. Quoted in Scull *The Insanity of Place/The Place of Insanity* p. 174.

¹⁷² Individual Correspondence Henderson, Dated July 28th 1912 Box I/1659/2, AMC.

¹⁷³ Henderson and Gillespie *Text-Book of Psychiatry* (1927) p. i.

within the wider hospital system. Without the promise of promotion or the power to implement change, Henderson fast retreated to the shores of North America, to the city of Baltimore, ready for the grand opening of the Phipps.

Baltimore – Henry Phipps Psychiatric Clinic 1912-1915

By the autumn of 1912, Henderson had sailed to America on the Anchor Line's *Columbia* and, after a brief visit to see Campbell in New York, arrived at the Phipps to take up his position as Senior Resident. To Henderson's disappointment, building had run behind schedule by several months and he was therefore without employment or accommodation. He was kindly taken in by the Meyers to live in their family home, and Henderson wrote that, from getting to know them on so intimate terms, he came to 'develop a deep and lasting affection for them'.¹⁷⁴

In the interim period between Henderson's arrival and the opening of the clinic, Henderson established working relations between himself and the medical staff of the Johns Hopkins Medical School, upon whose campus the Phipps Clinic was being built. He accompanied several doctors around the 'surgical, gynaecological, paediatric and urological departments to see patients who had developed psychological complications', and his engagement with the mainstream medical profession was, as Henderson recalled, a 'most stimulating and valuable experience'.¹⁷⁵ Outside of the Medical School, Henderson supplemented his research on psychiatric patients by working with some of the long-term prisoners at the Baltimore Penitentiary. His experiences with these prisoners influenced the future progression of his career, for, seeing first hand the injustice of criminalising and incarcerating individuals of poor mental health, he was also made aware of how often courts of law overlooked the life histories of such patients. As I go on to discuss in chapter seven, this realisation duly informed his pioneering research into the 'psychopathic states', the forerunner to today's diagnosis of the personality disorders.¹⁷⁶

On 16th April 1913, the Phipps was officially opened, with the lavish ceremony attended by such notable practitioners as Mott, Bleuler, (Ernest) Jones and Hoch. As Meyer stood

¹⁷⁴ Henderson *The Evolution of Psychiatry in Scotland* p. 182.

¹⁷⁵ Henderson's interest in the skills and facilities provided by the other medical professions saw him later transform the interior of Gartnavel in the 1920s, adding a dental department, a surgical ward and an occupational department to its interior arrangements. Henderson *The Evolution of Psychiatry in Scotland* p. 216.

¹⁷⁶ Henderson *Psychopathic States*.

among them, he declared those involved in the creation of the building had erected a ‘true clinic... a hospital for practical work, research and teaching’.¹⁷⁷ Situated on the Johns Hopkins Medical Campus, the Phipps, in its design and its situation, functioned not only to provide care to the mentally ill, but also to integrate the study of mental illness with hospital medicine.

For those visitors who passed through the grand entrance hall and out across the garden courtyard, they looked upon a building specifically designed to facilitate the practice of psychobiology. In alignment with Meyer’s specifications, two small wings stood across the courtyard, respectively to house the male and the female patients. In the main building, teaching spaces, research laboratories and treatment facilities were designed to unite the once disparate professional spheres of neurologist, pathologist, therapist and psychiatrist. A well-stocked library, a lecture hall, histological laboratories and photography rooms were made available to the Phipps’ medical staff, together with a hydrotherapeutic suite, gymnasium, large auditorium and roof top terraces. The terraces provided a semi-outdoor space where the principles of Meyerian psychiatry could be fulfilled, as patients were offered occupational and leisure activities such as billiards, sewing, painting, and craft classes. Meyer decreed it an essential prerequisite to psychiatric treatment that the Phipps create an ‘environment which really suits as far as possible the needs of the patient’. Through the provision of ‘rest for the one, amusement and distraction for the other, and a routine of simple quiet occupation and play for the large body’, Meyer sought to create standards of how to ‘spend a *day*, and perhaps *weeks*, in a way in which a mind can find itself again if it is at all *possible*’.¹⁷⁸

‘Uniting all of these spaces’, writes Lamb, was Meyer’s psychobiological theory of ‘the whole “person”, in constant adaptation to his or her environment’.¹⁷⁹ Each patient history revealed distinct, observable responses of a biological organism to set environmental conditions, and these responses constituted the ‘potentially controllable and predictable experimental phenomena’ which could be replicated and consequentially modified within the hospital environment.¹⁸⁰ By teaching the patient to modify their behaviour in

¹⁷⁷ Adolf Meyer ‘The Purpose of the Psychiatric Clinic’ first published in *The American Journal of Insanity* Vol LXIX 5 (1913) Special Number p. 86, reprinted in *The Collected Papers of Adolf Meyer Vol II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) p. 78.

¹⁷⁸ Meyer ‘The Purpose of the Psychiatric Clinic’ p. 78.

¹⁷⁹ Lamb ‘Pathologist of the Mind’ p. 144.

¹⁸⁰ Lamb ‘Pathologist of the Mind’ p. 181.

accordance to the standards of the clinical environment, Meyer envisaged the patient would build up ‘normal’, healthy habits of adaptation that would enable them to conform to the wider standards of society. The use of the Phipps as a therapeutic space, and also an experimental stage to which the patient was required to adapt, was all part of Meyer’s approach; and therefore what lay beyond the ornate lobby was the culmination of Meyer’s psychobiological principles, cemented in bricks and mortar.¹⁸¹

The purpose of the Phipps, wrote Henderson, invariably differed from that of the typical mental hospital. It catered to patients who were in the early acute period of illness, and as such the Phipps was designed to provide short-term treatment for ‘psychoneurotic patients and for acute affective, ideational, toxic and organic diseases of the central nervous system’. Existing asylums, stated Meyer at the Phipps opening, were too ‘exclusively limited to the care of more or less extreme cases’. The Phipps was seen to differ as it aimed to treat not only some of the most advanced and hopeless of cases, but to fight for the ‘prevention’ of mental disorder through early intervention.¹⁸² The main criterion for admission, wrote Henderson in 1914, was that patients and their families showed a reasonable amount of cooperation. The admission of voluntary patients was a high priority, and Henderson stressed that the ‘line of division’ between those patients predisposed to recovery and those who failed was often drawn, not between ‘any supposed standard of sanity or insanity’ but between the ‘cooperative and non-cooperative’ patients.¹⁸³ The expectation of the cooperative patient was that they would conform to the social reality structured by the hospital and its staff. In reality, however, cooperation was not always achieved, as one letter, written by Meyer to one of his more disruptive patients in 1913, demonstrates:

My dear Mr. Locke

After our conversation this afternoon it seemed to me that it might be well to leave with you a brief statement of what I should like to attain with you. The first point is absolute cooperation with the requests of your physician. It is no doubt hard for you to understand at the present time how very distractible and how easily influenced by casual impressions and desire you are ... The main purpose for you coming here is not to go to Harvard dinners or to make plans for traveling or

¹⁸¹ Henderson, on his return to Scotland, was restricted by the physical constraints of Gartnavel asylum, but he followed in footsteps of his mentor, as he manipulated the interior of the asylum, building dental, surgical and occupational departments.

¹⁸² Meyer ‘The Purpose of the Psychiatric Clinic’ p. 86.

¹⁸³ D. K. Henderson ‘Remarks on Cases Received in the Henry Phipps Psychiatric Clinic’ *Bulletin of the Johns Hopkins Hospital* 30, 277, March (1914).

anything of that sort, but really to settle down to a regime which will assure your getting on a normal basis. After we failed with giving you wider latitude, and after you proved to be unable to keep to your room, and to accept the plan of gymnastic exercises, and to refrain from taking advantage of your situation in which you can plunge in and strike as you please without having to expect a thrashing in return, it was absolutely necessary to plan the simplest possible arrangements for you.¹⁸⁴

Indeed, it is evident that during the first few months of Henderson taking up his position, the delicate balance between securing the cooperation and confidence of patients and their family, and providing an effective regimen of treatment, was not always met with a satisfactory outcome. Correspondence, written between Meyer, the Clinic's patients and their family doctors, reveal that Henderson came into confrontation with a number of patients and their families, so that a compromise had to be reached between the ideal standards of care and the reality of the individual situation. 'Mr Locke', wrote Meyer to the family doctor of the above troublesome patient:

I am sorry to say, is irrevocably opposed to any cooperation ... Unfortunately, whenever he has been given any liberty at all he has so far overstepped it that Dr. Henderson was forced to restrict him again, and the consequence is a declaration of absolute antagonism to Dr. Henderson.¹⁸⁵

In another letter written by Meyer, Henderson seems once again to have ruffled feathers, this time leaving the mother of the patient, a Mrs Steadman, in a rather perturbed state. After Mrs Fielding had brought her daughter into the Phipps, Henderson's suggestion that her daughter was suffering from epilepsy was taken rather badly, and she sent a letter of complaint to Meyer. As Meyer regarded the mother's reaction as an 'irate', unreasonable response to Henderson's candid analysis of the patient, Meyer diverted his correspondence from Mrs Fielding, writing instead to the patient's family doctor:

I regret the incident which is brought to my notice in [Mrs Fielding's] letter to you. The tone of the letter makes it undesirable for me to give a reply ... I might however write to Dr [Fielding], or any sensible member of the family ... Here ... we deal with the mother of a defective child ... To tell the mother that the daughter was clearly a case of imbecility would evidently have been taken as an insult – that the mention of the word "epileptic" could bring out such wrath shows however what timber the poor girl is derived from. Dr Henderson took the girl's pressure for nocturnal wandering

¹⁸⁴ Series XV Patient Correspondence (Ra-Sh) A13 dated May 14th 1913 AMC.

¹⁸⁵ Series XV Patient Correspondence (Ra-Sh) A13 dated May 21st 1913 AMC.

as a simple manifestation of epileptoid pressure. Had he spoken of the probable foundation in sexual unrest the mother would have been even less reconciled to accept reason.¹⁸⁶

The delicate system of relations that bound Henderson to his patients and their family members was clearly built up through a system of trial and error. The contradictory requirements of the psychiatrist to foster relations of trust and empathy with his patient and their family, while still maintaining a strong degree of power and dominance, demanded that the psychiatrist be adept at tailoring the tone and content of their conversation to every individual temperament. In case note records, the fluctuation of power relations between patient and asylum staff was often noted, and it is easy to read such records as merely evidence of the asylum's disciplinary regime. Once taking the psychobiological philosophy into consideration, however, this is an oversimplification. As the psychiatrist's power lay not only with their ability to dominate the patient, but also with their ability to gain their free cooperation and trust, what emerges most clearly from these letters is the negotiation of power as it ebbed, flowed and reverberated between family members, patients and psychiatrists.¹⁸⁷

After the first few months of the Clinic's opening, Meyer set sail across the Atlantic to London and then on to tour Switzerland, so that Henderson was left in a position of great responsibility. Henderson oversaw the training of interneees and the treatment of the Clinic's patients, and was in regular correspondence with Meyer. Reports of patient progression were sent overseas, alongside a number of patient case note records that enabled Henderson to obtain long-distance consultations. As I go on to explore, this use of single case histories to communicate matters of treatment and diagnosis overflows into his published works, as seen in future publications and *Text-book* entries.

As well as Henderson working at the Phipps, Meyer's staff also worked shifts in the Out-Patient Dispensary, and it is here that Henderson again practised alongside Meyer's 'second in command' Dr. Macfie Campbell.¹⁸⁸ Situated in a small building to the rear of the main Clinic, it was here that patients who were un-desirous of institutional care could receive psychiatric help. For Meyer, it was envisioned that the Dispensary would act as one

¹⁸⁶ Series XV Patient Correspondence Ab-Ar (Series A1) dated 16th June 1913 AMC.

¹⁸⁷ Henderson and Gillespie *Text-Book of Psychiatry* (1927) p. 75.

¹⁸⁸ Lamb 'Pathologist of the Mind' p. 122.

of a range of essential services, facilitating patients' readjustment to society.¹⁸⁹ As part of a network of social, cultural, medical and academic institutions, made up of teachers, social workers, psychiatrists, lawyers and churchmen, the Dispensary was envisaged as a space promoting the aims of the emergent mental hygiene movement, which was taking hold of American society.¹⁹⁰ 'We reali[s]e to-day', wrote Meyer in 1912:

... that nothing short of a hygienic sociali[s]ing of the community will achieve results, and this means an adequate out-patient and social service department, and in addition an elastic system of admission and discharge and follow-up work.¹⁹¹

Mental hygiene was especially aimed towards the education of children and the early prevention of mental disorders, and Campbell took an interest in childhood psychiatry.¹⁹² With children as well as adults arriving at the Dispensary, the Phipps medical officers had the chance to instruct parents, social workers and out-patients in the principles of mental hygiene.¹⁹³ The aim of treatment, noted Campbell, was 're-educational'; and, with the aid of four social workers, Miss S. Jean, Mrs Margaret Ware, Miss M. Moore and Miss M. Pope, Phipps staff extended their studies beyond the walls of the Dispensary.¹⁹⁴ The work of the social worker, reflected Campbell, '... takes one from the dispensary into the home and brings one face to face with the vital problems of the mental hygiene of the community'.¹⁹⁵

Working between the Dispensary and the Clinic, Henderson related how he and his fellow colleagues graduated from thinking in terms of 'sterile concepts of sanity and /or insanity but whole heartedly applied [them] selves to positive, remedial aspects of assisting those

¹⁸⁹ A common goal of North American pragmatism was to 'pursue academic research that yielded practical applications for the individual and society', and within this philosophical framework Meyer was a staunch supporter of mental hygiene and social welfare provision. Lamb 'Pathologist of the Mind' (2014) manuscript in preparation for publication 'Chapter 2' p. 25.

¹⁹⁰ C. Macfie Campbell 'The Responsibilities of the Universities' *Proceedings of the Mental Hygiene Conference and Exhibit at the College of the City of New York* Nov 8th-15th (1912) 90-95 p. 92.

¹⁹¹ Adolf Meyer 'The Aims of a Psychiatric Clinic' *Proceedings of the Mental Hygiene Conference and Exhibit at the College of the City of New York* Nov 8th-15th (1912) 117-127 p. 122.

¹⁹² The mental hygiene movement, which was founded in the years leading up to 1908 by Clifford Beers, (a former psychiatric patient), Adolf Meyer, the physician William H. Welch and the philosopher William James, aimed to improve standards of care and to re-educate public attitudes towards psychiatric patients. See Manon Parry 'From a Patient's Perspective: Clifford Whittingham Beers' Work to Reform Mental Health Services' *American Journal of Public Health* 100, 12 (2010) 2356-57. p. 2356.

¹⁹³ Campbell 'The Responsibilities of the Universities' p. 91.

¹⁹⁴ Alysia Young Han 'Children's Mental Health in the United States: The Development of Child Psychiatry at Johns Hopkins, 1890-1945' (Unpublished Dissertation, Berkley: University of California, 2012) p. 15.

¹⁹⁵ Charles Macfie Campbell 'The Role of the Psychiatric Dispensary: A Review of the First Year's Work of the Dispensary of the Phipps Psychiatric Clinic' *American Journal of Insanity* Vol LXXI, 3, Jan (1915) 451-457 p. 451.

who had come for help'.¹⁹⁶ To place patients wholeheartedly in rigid diagnostic categories that separated the sane from the insane, was seen to stigmatise the patient while lending credence to the often over pessimistic attitude of materialist psychiatry and the public at large. This concern was expressed in no uncertain terms in the following letter, written by Meyer to one of his patient's relatives, as he criticised their use of the term 'lunatic'. Exemplifying how the philosophy of the institution extended well beyond the walls of the clinic, this letter sees Meyer striving, one correspondent at a time, for a linguistic and ideological revolution. Endeavouring to remove mental illness from the 'mysterious preserve of the specialist' and to demystify its meaning to the general public, Meyer wrote:

July 25th, 1912

Mrs Frank C. Bisby

... I have, with due apologies, to make a pointed remark to an expression in your letter, which no doubt explains to some extent the feeling you have concerning Bloomingdale [Insane Asylum]. You say: "I hate to put her among lunatics except as a last resort". It is most unfortunate that we should have to use in this 20th century the harsh and non-discriminating term "lunatic". I am quite sure you would not care to have other people apply it to your daughter, and yet, with my full knowledge of the case, I could not say what on earth would differentiate such a mental disorder as your daughter's from the mental disorders of the patients at Bloomingdale, ... they are all patients for whom the physicians are trying to do their best, everyone with their special difficulties to be adjusted as well as possible ...¹⁹⁷

Alongside such difficulties, life in the Phipps was also interspersed by moments of joviality. The behaviours and mannerisms of a good number of patients were fondly portrayed within *The Evolution* and, as the following excerpt demonstrates, Henderson endeavoured to capture something of the everyday occurrences that preoccupied their time, adding to an understanding of the individual personalities of the Phipps' patients:

An irate Consul from one of the Southern States found one morning that by some mischance he could not find his trousers. Miss Roder, his special nurse, charmingly maintained that she could not imagine what had happened to them, but it did not prevent him from disturbing the other patients by parading the corridor loudly exclaiming: 'For god's sake, Miss Roder, give me my pants'.¹⁹⁸

¹⁹⁶ Henderson *The Evolution of Psychiatry in Scotland* p. 188.

¹⁹⁷ Patient Correspondence Series XV Box A5 Cl-De dated July 25th 1912 AMC.

¹⁹⁸ Henderson *The Evolution of Psychiatry in Scotland* p. 190.

In 1915 a note sent by Henderson from the Clinic to Meyer, who was once again on holiday, revealed that, alongside business correspondence, Meyer had posted a ‘fine milky’ coconut that had caused quite a stir when it arrived upon Henderson’s desk. In 1911, meanwhile, a dinner dedicated to Henderson, attended by Campbell, Hoch and Meyer amongst others, saw the dining table adorned with Scotch thistle place name cards and songbooks (see figure 4). The evening included a recital of:

For he’s a jolly good fellow,
For he’s a jolly good fellow
...Who is this jolly good fellow?
HENDERSON, HENDERSON Ay!¹⁹⁹

By August 1914, Henderson was fully immersed in his work at the Clinic, his career brimming with possibilities; and yet, as British politicians announced a declaration of war on Germany, Henderson was pulled by feelings of duty to return to Scotland. After being informed in 1914 that the army was not presently in need of more medical personnel, Henderson’s return to Scotland was forestalled until he received news that Dr. Landel Rose Oswald, the Physician-Superintendent of the Glasgow Royal Lunatic Asylum, was desperately in need of an assistant. Therefore in March 1915, Meyer wrote a glowing letter of recommendation to Oswald and Henderson set sail for Scotland to take up the post of Senior Assistant at Gartnavel.

The stark contrast between life in America and that, which welcomed him in Europe, made its impression upon Henderson as the ship docked in Liverpool harbour. Henderson wrote to Meyer that, after spending the last few nights of the journey ‘on the lookout for German submarines’, they arrived to see a crowded wharf, full of cheering onlookers waving off British troops ‘en route’ for the Dardanelles.²⁰⁰

Gartnavel and the Great War 1915-1918

Unlike the Phipps, which was equipped with new technological advances and situated in the very heart of Baltimore city, Gartnavel Mental Hospital stood in stark contrast (see figure 5). Built in 1840, the site chosen for Gartnavel (which was then referred to as

¹⁹⁹ Small booklet, tied together with ribbon, the front page of which has a hand drawn thistle on the front with ‘Dr Henderson’ written in pencil on top. Dated the 15th July 1911, Meyer, Box I/1659, AMC.

²⁰⁰ Individual Correspondence Henderson, 5th June 1915 Box I/1659/5 AMC.

Glasgow Royal Asylum) lay to the West of the City of Glasgow, located in a semi-rural location alongside Great Western Road.²⁰¹ Raised upon a hill that overlooked the institution's extensive grounds (66 acres), the asylum commanded views that looked across to the Campsie Hills, Paisley and the River Clyde, while eastward lay the City of Glasgow. Designed by the architect Charles Wilson, an imposing Tudor Gothic style building rose above the cityscape, while six-foot high walls encased the perimeter of the property.²⁰²

Oswald, deferentially known as the 'Chief', was described by Henderson as a 'tall, angular, hatchet-faced man[,] with a thick moustache'.²⁰³ Upon first meeting him, Henderson reflected he could seem 'a little overpowering'. Nursing and medical staff 'tended to be afraid of him', but for those who 'stuck to their guns they earned his respect and admiration'.²⁰⁴ Oswald (1861-1926), who began his training in medicine at the University of Glasgow in the 1880s, had himself studied on the Continent and in the United States. Having first worked as an Assistant Physician at the Gartnavel in 1889, he was awarded a travelling scholarship, and upon his return to Glasgow in 1895 he was appointed Physician-Superintendent of the Glasgow District Asylum, Gartloch, before succeeding David Yellowlees as Physician-Superintendent of Gartnavel in 1901.²⁰⁵

As at Morningside, Gartnavel catered for the rigid class and gender divisions entrenched in British society. Apportioned into two separate structures, an East House was originally designed to cater for pauper patients while a more sumptuous West House catered for a private, fee-paying clientele. From the 1890s onwards, Gartnavel became dedicated to the care and treatment of private patients only, and an overhaul of the Asylum's interior was made to lessen the distinctions between East and West House. Despite internal modernisation, however, the patient population remained segregated by class, and these

²⁰¹ For more information on the architectural design of rural Scottish and British asylums in the early 1800s – 1860s see Philo *A Geographical History of Institutional Provision for the Insane* and Kim Ross 'The Locational History of Lunatic Asylums/ Mental Health Institutions in Scotland: archival inquiries and contemporary resonances' (Unpublished Thesis, Department of Human Geography, University of Glasgow, 2014).

²⁰² Ann Snedden 'Environment and Architecture' in *Let there be Light Again' A History of Gartnavel Royal Hospital from its Beginnings to the Present Day* pp. 30-31.

²⁰³ Smith and Swan 'Medical Officers and Therapeutics, 1814-1921' p. 54.

²⁰⁴ D. K. Henderson 'Glasgow Royal Mental Hospital' in *The Scottish Society of the History of Medicine, Report of Proceedings, Session 1962-63* (1963) p. 22.

²⁰⁵ Anon 'Dr. Landel Rose Oswald, M.B., C. M. Glasg., M.P.C. Once Physician-Superintendent, Glasgow Royal Mental Hospital. Ordinary Member 1890-1926' *The British Journal of Psychiatry* 74 (1928) 366 p. 366.

divisions were reinforced in the hospital's physical layout and aesthetic adornments.²⁰⁶ On one side of the building lay the East House department, which accommodated lower rate paying patients within large, 'overcrowded, unadorned wards'. Henderson reported that, upon his arrival, day-room space was 'restricted' and the furnishing 'uncomfortable'. The West House department was, by comparison, 'well furnished', with higher fee paying patients accommodated in smaller, more comfortable and intimate wards. Single rooms afforded patients both greater privacy and specialised nursing care, while overlooking some of the more spectacular views over the Campsie Hills.²⁰⁷

After arriving at Gartnavel at the end of May 1915, Henderson found the asylum to be poorly staffed, with only three men, including himself, on hand to run the establishment while the rest of the male staff had enlisted. Overseeing the treatment of around 250 female and 200 male patients, this was in sharp contrast to the 60-70 patients in residence at the Phipps.²⁰⁸ Staff deficiencies meant that padded rooms and restraining sheets were frequently in use; and, for those patients deprived of an outdoor 'pass', the necessity of using the old airing courts to provide supervised outdoor exercise was considered a 'particular source of irritation'. Henderson noted that 'in certain instances these courts prevented a patient escaping', but, as patients were surrounded by high walls and iron railings, this 'allowed only the most limited outdoor exercise' and actually increased the frequency of escape attempts.²⁰⁹ Despite many material deficiencies, Henderson wrote to Meyer there was nonetheless 'any amount of most excellent material' to explore.²¹⁰

The mentally ill of Glasgow, Henderson was later to recall, many who were of 'Jewish and Irish extraction', were 'turbulent, excitable, aggressive', and contrasted sharply with the 'douce Edinburgh citizens' and 'gentle-mannered Orcadians' encountered previously at Morningside.²¹¹ The 'perpetual tension and uncertainty' of the war years was understood to

²⁰⁶ Despite class segregation, patients of either class were provided with a range of leisure and therapeutic facilities. Patients on parole were allowed to mix within the grounds (although largely under the watchful eye of nursing attendants), in dining halls, and, after the construction of the recreation hall 1877, male and female patients mingled in evening concerts. The grounds of Gartnavel provided the patient population with an array of outdoor occupations, with land laid aside for both cultivation and recreation and a bowling green, croquet lawn, tennis courts and a golf course were for the use of male and female patients, whilst a farm, in addition to glasshouses, tool sheds, and a piggery provided outdoor occupation for gentlemen patients. Snedden 'Environment and Architecture' p. 35.

²⁰⁷ Henderson *The Evolution of Psychiatry in Scotland* pp. 196-7.

²⁰⁸ *The Annual Report of the Glasgow Royal Mental Hospital* (Glasgow Royal Asylum) (Glasgow: Glasgow Royal Mental Hospital, 1914-1930) GB 812 HB13/2/101-117 NHSGGCA.

²⁰⁹ Henderson *The Evolution of Psychiatry in Scotland* pp. 196-198.

²¹⁰ Individual Correspondence Henderson, letter dated June 5th 1915 Box I/1659/5, AMC.

²¹¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 196-198.

have produced ‘irritation, suspicion, sleeplessness, exhaustion, malnutrition and fear’, and Henderson found himself administering to cases of ‘acute catatonic and stupor reactions, deliria, affective states, acute hallucinatory and delusional episodes, and agitated melancholias’.²¹² Compiling the case histories of several catatonic patients (a subgroup of dementia praecox), Henderson produced a paper entitled ‘Catatonia as a Type of Mental Reaction’. Here he expressed to a British audience the psychobiological principles of Meyer; exhorting the advantages of reaction type diagnoses, while his case histories were constructed in terms of ‘situation, reaction, and final adjustment’.²¹³ It is here that we see Henderson developing a more narrative style of writing, as he vividly detailed the family histories, the personal situations and the symptom pictures that gave meaning to the notion of ‘mental reaction’.²¹⁴

In addition to Gartnavel’s patient population providing such ‘excellent material’, Oswald had laid the groundwork for a socially orientated approach to psychiatry, having set up the first outpatient clinic in Scotland for the treatment of incipient cases in 1910.²¹⁵ Staffed by social workers that supported the clinic’s psychiatrists, Oswald instigated the development of a ‘social psychiatry’, which branched out into community settings.²¹⁶ Moreover, Oswald established a Department of Mental and Nervous Diseases in the Western Infirmary in Glasgow.²¹⁷ With such vital steps having been taken in the direction of a more scientific and socially informed practice of mental health care, it is unsurprising that Gartnavel was considered by Henderson as a most conducive atmosphere in which to pursue his study of its patients and to begin to apply Meyerian methods of treatment.

By September 1915 Henderson was writing to Meyer reporting he was thoroughly enjoying his life at Gartnavel, and again sent case abstracts of interesting patients for Meyer’s consultation. Within the hospital, Henderson was steadily introducing new administrative measures and therapeutic classes. ‘With the aid of one of the patients who has always been interested in physical drill etc’, an exercise class was set up for some of the lady patients, with occupation classes also being introduced. ‘My first impression of

²¹² Henderson *The Evolution of Psychiatry in Scotland* pp.198-99.

²¹³ D. K. Henderson ‘Catatonia as a Type of Mental Reaction’ *The British Journal of Psychiatry* 62 (1916) 556-572 p. 558.

²¹⁴ *Ibid* p. 560.

²¹⁵ *Ibid* p. 199.

²¹⁶ James Harper ‘Out-Patient Adult Psychiatric Clinics’ *British Medical Journal* 7 Feb (1959) 357-359 pp. 357-58.

²¹⁷ Smith and Swann ‘Medical Officers and Therapeutics, 1914-1921’ p. 61.

the whole situation is a very favourable one', wrote Henderson, but he also confessed to Meyer that the desire to do "my bit" was increasingly pulling him towards enlistment.²¹⁸

Wartime psychiatry

By 1916 Henderson enlisted as a wartime psychiatrist and was writing to Meyer from the Lord Derby War Hospital in Lancashire. 'It is all pretty miserable and depressing over here', he admitted:

I have charge of the admission service, and in consequence have had a most interesting and varied experience but the mass of material is so enormous, and they come in such large convoys that the work is almost paralysing.²¹⁹

With the war being fought across a number of fronts, stretching across Europe, Africa and Asia, it was recognised that soldiers were returning with an array of symptoms, including states of delirium, coma and extreme physical exhaustion due to malarial infection, heat stroke, sand fly fever and influenza. The 'so called Shell-shocked cases', wrote Henderson to Meyer, were of particular interest as it proved almost impossible to distinguish the extent to which such cases were due to 'psychic conflicts [or] to physical factors', while schizophrenic reaction types were most notable 'on account of their frequency, the rapidity of their onset, the intensity of their symptoms, and the quickness of their recovery'.²²⁰

Over the next two years, Henderson took advantage of the mass number of casualties passing through his hands to compile records of over 200 cases of 'Home troops' suffering from psychiatric disorders. In *The Evolution* Henderson reviewed this period of the early war years, admitting it was with a sense of great disappointment that he learned the extent to which neither the government nor the 'service chiefs' appreciated the contributions made by the psychiatric profession. The psychiatrist, he recalled, was 'regarded with disfavour if not with ridicule' while their methods of work were considered to be 'subversive rather than constructive'.²²¹ Thirty per cent of casualties, who passed through the hospital, claimed Henderson, were 'subnormal, feeble-minded youths' who should

²¹⁸ Individual Correspondence Henderson, Dated 26th September 1915, Box I/1659/5 AMC.

²¹⁹ Individual Correspondence Henderson, Dated 11th December 1916, Box I/1659/6 AMC.

²²⁰ Henderson *The Evolution of Psychiatry in Scotland* pp. 206-208.

²²¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 200-202.

never have been enlisted. He used their example to stress the value of simple tests of intelligence, which, had they been carried out, might have spared their mental health.²²²

In 1917 Henderson was posted to France to take up general medical duties and became a regimental officer attached to the Royal Sussex and Suffolk regiments stationed at the Ypres-Arras Sector. No great battles were fought during this time and there was a general lull in the fighting, but for Henderson, to be in the scene of warfare, to tread the mud-caked duckboards, to survey a landscape of bomb craters and demolished buildings, and to live in dug outs surrounded by the constant smell and sight of death, all made for a deeper appreciation of the stress and strain experienced by his patients.²²³ By the winter of 1917, Henderson was granted a brief period of leave to sail to America, where, at the age of 33, he married Margaret Van Vranken Mabon, daughter of Dr William Mabon, Superintendent of the Manhattan State Hospital.²²⁴ Upon his return he was posted to Netley military hospital in Hampshire, where he worked to sort psychiatric casualties, before overseeing their distribution to mental hospitals throughout the country. From the special department “D Block”, for mental disorders occurring in overseas forces, Henderson wrote to Meyer that, ‘as our accommodation is only for approximately 140 cases[,] we never have our cases for more than 48 to 56 hours, and in consequence it is almost impossible to do any decent work on them’. The majority of these casualties, reported Henderson, were Dementia Praecox, G.P.I. or Mental Deficiency, all of whom, Henderson argued, should never have been enlisted in the first place. ‘I wish this old, beastly war was finished’, concluded Henderson in his letter to Meyer, ‘but on the other hand there does not seem to be any possible outcome except to stick it to the bitter end’.²²⁵

By December 1918, Henderson published a substantial report entitled ‘War Psychoses – Dementia Praecox in War Time’, the culmination of the 200 case records so diligently compiled throughout his service during the war years. In this report he pushed home the message that the indiscriminate enlistment of men in the early years of the war had proven detrimental not only to the mental health of the nation, but also to the economic stability of

²²² Ibid p. 209.

²²³ Henderson *The Evolution of Psychiatry in Scotland* p. 209-210.

²²⁴ In a photograph sent by Henderson to Eunice Winters, Meyer writes on the back of the photograph, identifying Dr William Mabon as his father in law. Box 4 of 7 ‘Colleagues, Friends, Staff’, Photography Collection, AMC.

²²⁵ Individual Correspondence Henderson, Dated 6th March 1918, Box I/1659/6 sent from ‘Officers Quarters, Netley’ AMC.

the country. By using the individual stories of many patients, he concluded that they showed ‘over and over again that’:

... a great many of these patients have had an abnormal make-up, have previous to enlistment been in asylums, or have had definite mental symptoms without asylum treatment, and have broken down within a few weeks or months after being sent abroad.²²⁶

Together with the peace time personality studies of Hoch and Meyer, it is here that Henderson used studies of constitution with poignant effect, distinguished individuals considered ‘constitutionally inferior’ whose break down under war time conditions was predictable and arguably preventable. After two or three months of work at Netley, Henderson was transferred back to Scotland to the Dunblane War Hospital, Perthshire, and it was here that Henderson spent the remainder of his military service. The patients who Henderson treated were all suffering from neuroses, characterised by states of ‘blindness, mutism, deafness, paralysis ... or by anxiety reactions presenting as palpitation ... panic, fear, obsessive-compulsive reactions, nightmares and sleeplessness’.²²⁷ Henderson’s dynamic approach to the treatment of the neuroses enabled him to apply his psycho-analytic training *en masse*, ‘but we did not always encourage them ... to recall the painful, emotional experiences they had had’. The act of forgetting was, in many cases, believed to be a kinder release from their recent troubled past.

The return to Gartnavel

By November 1919, Henderson’s war work at Dunblane was coming to an end, and once again he approached Meyer for references to accompany his applications to Scottish asylums. After receiving glowing references from Meyer, Henderson applied to a number of establishments, but one by one they all turned him down. The last of Henderson’s failed applications was for the Royal Murray Asylum, Perth, and Henderson wrote to Meyer, in exasperation, of the conservative and dogmatic hold that the ‘great men’ of Scottish psychiatry had over his fate.

²²⁶ D. K. Henderson, Captain (Temp) R.A.M.C., Royal Victoria Hospital, Netley ‘War Psychoses – Dementia Praecox in War Time’ *Review of Neurology and Psychiatry*, November-December, 1918 pp. 2-3.

²²⁷ Henderson *The Evolution of Psychiatry in Scotland* p. 211.

Dear Doctor Meyer

Your letter of December 20th has just arrived, and I may say at once that the Murray has decided against me, and went to Ross ... It has been rather a disappointment because Ross is not only my junior in years, but also in graduation, in experience, training etc. The reason given for his appointment is because Brown, promoted to Aberdeen, was a Morningside man, and the Directors thought that Ross [also of Morningside] would be more likely to carry on the policy of Brown. As a matter of fact psychiatric experience and training practically does not count, and the other day Dr Robertson of Morningside told me no doubt the fact that I had written so many papers was against me, and also that it would have been better if I had stuck to one place ... The position here now is that practically the only job I can get is to go back to Gartnavel as 1st Assistant – but even that I am not yet sure of. Dr. Oswald expects to retire in two years time, and the hope is then held out that I might possibly succeed him, but the board of Directors would not be willing to make any definite agreement with me.²²⁸

It is arguable that Henderson offered a far too radical challenge to the status quo. With the continuation of method and tradition seen as being favoured over experience and innovation, Henderson's return to Gartnavel was in many ways a last resort. His ambition and no doubt pride dented, he returned to Gartnavel to take up his old position, while his fate lay with a Board of Directors whose criteria he had to fulfil. During those first few months when Henderson resumed his work at Gartnavel, his desire to return to the Phipps was once again reawakened and he wrote to Meyer asking to be considered for upcoming opportunities. By late autumn of 1919 Meyer offered Henderson a post, but by this time something had strengthened the appeal of his position within Gartnavel, and with great reluctance Henderson declined Meyer's offer. 'I have failed you so far as America is concerned', wrote Henderson in mid-November, 'but I can assure you that I shall try to be true to your teaching and influence'.²²⁹ In reply to Henderson's letter, Meyer wrote:

My dear Dr. Henderson

It was a matter of great disappointment that your decision turned against us ... I reali[s]ed, of course, from the beginning that you might have changed your attitude contained in your earlier request to receive consideration in an appointment on this side. I am glad to know that your opportunities at Gartnavel have taken such satisfactory shape, and in many ways I feel that you are right in assuming that you

²²⁸ Individual Correspondence Henderson, Dated 9th January 1919, Box I/1659/8 AMC.

²²⁹ Individual Correspondence Henderson, Dated 14th November 1919, Box I/1659/8 AMC.

can make a stronger impression on practically virgin soil in a good sturdy environment.²³⁰

Gartnavel, against all odds, was now considered to provide the right environment in which to cultivate the dynamic, psychobiological approach of Meyer, and thereby to instil his teaching and influence upon the ‘virgin soil’ of British psychiatry.

What changed within these months to make Gartnavel such a fertile ‘environment’ is partly open to conjecture - very little is revealed by the Meyer-Henderson correspondence or by *The Evolution* - but it is justifiable to suggest that two significant events swayed matters. Firstly, Oswald had greatly encouraged Henderson in 1915 to integrate his dynamic principles at Gartnavel, and it is evident that, upon Henderson’s return, these two men continued to hold similar beliefs regarding certification reform and the need for psychiatrists to change ‘public opinion’ as to the cause of mental illness. In the *Annual Report* for the year 1920, Oswald spoke of mental illness in terms that were emphatically congruent with Meyerian principles, as he wrote that ‘mental disorder should be looked upon as ... a reaction to a situation’, whether it be ‘alcohol or syphilis or drugs or ... mental worry, domestic unhappiness, grief’.²³¹

Oswald, after falling ill in 1919, was prevented from taking an active role in the management and treatment of his patients, and Henderson’s chance of promotion may have presented itself as a real possibility. After having acted as Physician-Superintendent during this year, Oswald publicly announced in the *Annual Report* that ‘[i]t was a comfort to me to know that Dr. Henderson was available to carry on my work, which he has done with great ability and success’.²³² Publicly praised by Oswald in the *Annual Report* for so aptly taking over the duties of Physician-Superintendent, Henderson must have felt greater security in his future chances of succession.²³³ Both ideologically and practically, the environment of Gartnavel was suitable for the introduction of dynamic psychiatry. Oswald’s early retirement meant that, by 1921, Henderson had gained his long sought promotion and rose to Physician-Superintendent of the Glasgow Royal Mental Hospital, Gartnavel.

²³⁰ Individual Correspondence Henderson, Dated 28th November 1919, Box I/1659/8 AMC.

²³¹ Llandel Rose Oswald ‘Report of the Physician-Superintendent for the Year 1920’ The One Hundred and Sixth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) For the Year 1920 GB812 HB13/2/107 p. 20.

²³² Ibid p. 24.

²³³ Llandel Rose Oswald ‘Report of the Physician-Superintendent for the Year 1920’ p. 24.

Conclusions

When reflecting on this chapter, the significance of Meyer's case taking guides and staff meeting outlines to an emerging trans-Atlantic movement of dynamic psychiatry becomes clear. From Meyer's first unofficial staff meeting at Kankakee in the 1890s, to Campbell's introduction of Meyerian case taking outlines at Morningside in 1908, to Henderson communicating with Meyer across the Atlantic via the production of case histories in 1915, standardised methods of case note taking and examinatory procedures facilitated the spread of dynamic psychiatry. Despite Meyer lacking a text-book of his own with which to promulgate his ideas, it was through a small but gradually expanding network of colleagues, each of whom abided by Meyer's rigorous set of 'standards', that the dispersal of his methods was achieved. A history, therefore, which is reliant on published source materials alone cannot truly understand the diaspora of Meyerian psychiatry, unless these sources are read alongside the unpublished, personal correspondence. It is the practical application, as well as the theoretical apparatus, of Meyer's ideas, methods and clinical practices that correspondence records help to unveil. They speak precisely of individual cases, clinical environments and socio-geographical spaces in which these moments of creation and transition were set, inserting an 'alertness to details, difference and, as a result, geography into the story being unfolded'.²³⁴

As the history of dynamic psychiatry is in so many ways the history of movement and the spread of knowledge across differing institutions, cities and continents, it is clear that such a history may profitably be explored through the lens of the human geographer. There is evidently a narrative, underwriting these letters, which speaks of the outsider's struggle for power and recognition; and, when we look to the spread of ideas from one country to another, these letters speak of the professional, as well as geographical, borders that needed to be surmounted. When expressing their opinion on the state of British psychiatry, Campbell, Meyer and Henderson largely speak of stagnation and impenetrability; of an outmoded profession tied to the routines, philosophies, languages and buildings of the Victorian era. The Phipps, by contrast, was built to embody physically the psychobiological approach; demonstrating the perceived necessity of the dynamic psychiatrist to manipulate the clinical environment to which patients should adapt.

²³⁴ Philo *A Geographical History of Institutional Provision for the Insane* p. 36-37.

The interpersonal contexts in which these letters were produced are also noteworthy. Penned between mentees and mentor, they were produced under conditions where the possession of authority and influence weighed heavily towards Meyer, leading one to question how far Henderson's letters reflect his own personal opinions, and how far they were influenced by factors of patronage and his allegiance to Meyer. These subtler inferences can further be questioned when considering the differences between Henderson's early correspondence and his later portrayal of this period in *The Evolution*. When Henderson's early career is judged through the lens of contemporary correspondence, polarities between the respective states of British, Continental and North American psychiatry are more exaggerated than is the case within *The Evolution*. Written in the latter years of his career, *The Evolution* expresses a more tempered, even complimentary portrayal of his British professional peers. Moreover, while correspondence reveals Henderson's repeated rejection from posts of authority in British mental hospitals after the war, this was not mentioned at all in *The Evolution*. It is only through his correspondence that we hear Henderson's damning report of nepotism, allegedly shown by British psychiatrists, who favoured those men who had 'stuck to one place' and towed the party line.

It is therefore arguable that these letters expose the energy and frustration that accompanied a young man's early career. They uncover the strength of feeling evoked by the expansion of his knowledge and expertise, and the temporary stunting of his confidence and ambition. They uncover the pivotal spaces - the wards, teaching theatres and meeting rooms - in which dynamic psychiatry was promulgated, while revealing something of the personal characteristics and professional interests which drew these men and women together to form the Phipps school of psychiatry. The British psychiatric profession, though in many ways condemned, is shown to have persevered despite a lack of educational, laboratory and modern clinical conditions, while the foresight of individuals such as Oswald paved the way for a new generation of psychiatrists to incorporate Continental and North American psychiatric achievements within the old Victorian asylums.

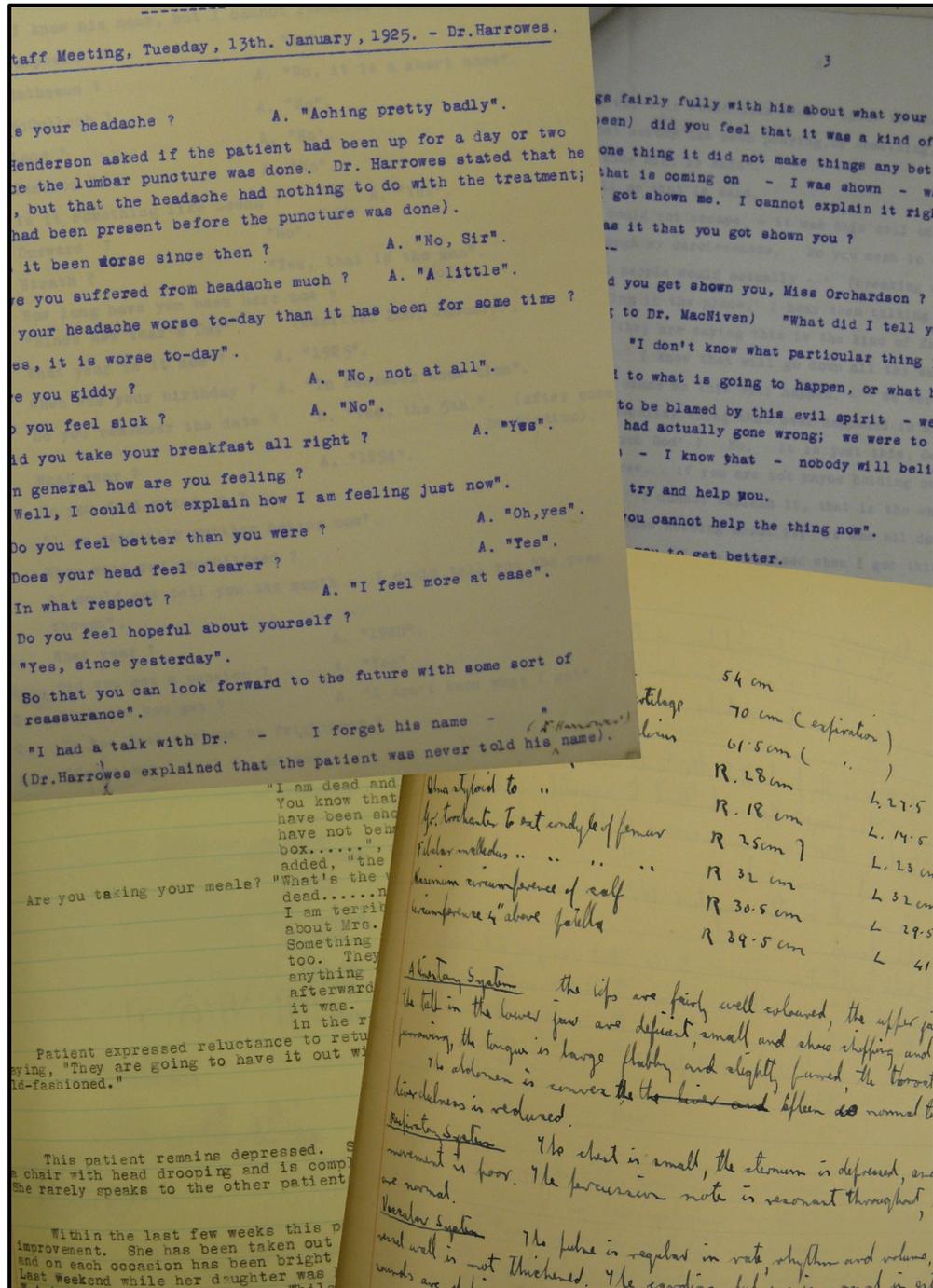
As the first Physician-Superintendent to instigate dynamic methods in an established British mental hospital, Henderson's significance to the history of dynamic psychiatry is, in part, that he promised to act as a counterweight to the established, somatic orientation of the British psychiatric profession. What is also clear is that Campbell may equally have

taken up this role if an opportunity had arisen for his promotion. Through Campbell in the early twentieth century, bridges were already being assembled between British, Continental and North American dynamic psychiatrists, but the established method of promoting physician-superintendents from within the ranks seems to have stunted his professional advancement. Gartnavel in the post war period, however, had already been primed by Oswald to take on a more scientific, socially orientated approach to the study and prevention of mental illness. This proved to be the chink in the armour of the established British psychiatric profession, and, upon Oswald's early retirement, Henderson was presented with a rare opportunity to hold a senior position. It was therefore part circumstance, part skill and perseverance, which enabled Henderson to pioneer the introduction of dynamic psychiatry into Britain, and more specifically Scotland, in 1921. Rather than consider Henderson's early career as the smooth trans-Atlantic movement of psychiatric ideas and clinical practices, correspondence therefore reveals a somewhat suppressed counter-narrative of struggle, rejection, patronage and dependence; a history which Henderson later endeavoured (consciously or unconsciously) to quell.

Figure 5. The top photograph is of Gartnavel's exterior taken from the *Annual Report of the Glasgow Royal Mental Hospital 1922*. Below and to the left of the top picture is a photograph of a West House Ward ref GB12 HB13/15/88 whilst at the bottom left hand of the montage there is the photograph of nurses on the West House ward GB12 HB13/15/89 *NHS Greater Glasgow and Clyde Archives*. The rest of the sporting and recreation photographs are taken from a 'Scrap book – cum- photo album', catalogue description: 'Black and white photographs of building (including Chapel under construction) Staff and patients (particularly of sporting and recreational activities) [Style of clothes suggests these date to Edwardian period] GB12 HB13/14/1. Copyright NHS Greater Glasgow and Clyde Archives. Printed with the kind permission of head archivist Alistair Tough.



Figure 6. Samples of case note and case conference documents, circa the 1920s, Gartnavel Mental Hospital. Copyright NHS Greater Glasgow and Clyde Archives. Printed with the kind permission of head archivist Alistair Tough. From clockwise, Case no 426 GB 812 HB13/5/184/23. Case no 460 GB 812 HB13/5/184/47. Case no 496 GB 812 HB13/5/185/31. Case no 302 GB 812 HB13/5/182/12.



CHAPTER THREE

ANATOMY OF THE ARCHIVES: A METHODOLOGICAL APPROACH

In the latter years of his life, Henderson looked back on his ascension to Physician-Superintendent in 1921, reflecting that ‘The Glasgow Royal, or Gartnavel as it was more familiarly known, was a formidable looking structure’. An ‘imposing, austere, dark grey building’, topped with crenelated walls and guarded by ‘tall ornamental iron gates’ Gartnavel stood in testimony to the stylistic pretensions and institutional ideals of the early Victorian era. Erected in 1843 ‘at a time’ noted by Henderson, ‘when security was the important if not predominant feature of mental hospital architecture,’ the building ‘could not easily be tampered with’. Nonetheless, despite the permanency of its colossal stone foundations, it was ‘possible to modernise its internal arrangements’.¹ Within Gartnavel, Henderson had at last gained the authority to implement his years of training upon the ‘virgin’ territory of Scottish ‘soil’, and with his years of clinical training brought to fruition he began to fully embed the dynamic approach within the hospital.

‘One of the first’ and most ‘enduring’ features of dynamic psychiatry seeping into the hospital building was the construction of the Occupational Therapy Pavilion and the appointment in 1922 of Scotland’s first Occupational Therapist, Miss Dorothea Robertson.² In emulation of Meyer, Henderson upheld his mentor’s assertion that the mental hospital should ‘create standards of how to spend a *day*, and perhaps *weeks*, in a way in which a mind can find itself again’, and within a pavilion that was bright, spacious, and which stood in a secluded area of the hospital grounds, Henderson hoped to provide ‘varied, congenial’ activities that drew the interests of a predominantly middle and professional class of patient.³ Instead of thinking of patients in terms of ‘groups’,

¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 196-7, 216. On Gartnavel’s architecture see also Snedden ‘Environment and Architecture’ p. 37.

² D. K. Henderson ‘Report of the Physician-Superintendent for the Year 1923’ *The One Hundred and Tenth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) for the Year 1923* HB13/2/110 NHSGGCA p. 23. See also Meyer ‘The Purpose of the Psychiatric Clinic’ (1913) republished within *The Collected Papers of Adolf Meyer Volume II Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) pp. 178-9. See also Snedden ‘Environment and Architecture’ p. 37 and Smith and Swann ‘Medical Officers and Therapeutics, 1921-1993’ p. 73 and Ross ‘The Locational History of Lunatic Asylums/ Mental Health Institutions in Scotland’.

³ Dorothea Robertson became the first instructress of Occupational Therapy to be appointed to Gartnavel in 1922, and was actually the first O.T. instructor in the whole of Britain. See Catherine F. Paterson ‘A Short History of Occupational Therapy in Psychiatry’ in *Occupational Therapy and Mental Health* eds. Jennifer Creek, Lesley Lougher (Philadelphia: Elsevier, 2008) p. 9. The predominantly middle class uptake of patients is detailed by Henderson in the ‘Report of the Physician-Superintendent for the Year 1922’ p. 20.

Henderson lectured to the Scottish Division of the Medico-Psychological Association in 1924: ‘... we must develop a more individual touch than has ever previously characterised mental hospital organi[s]ation...’⁴ By providing occupations such as silk painting, woodwork, basketry, china painting and rug making, Henderson envisaged the Occupation Pavilion as a place where patients could accomplish something ‘for themselves’, where individual interests and abilities were stimulated, and where occupational therapies could instil ‘[s]elf-confidence’, ‘self-esteem’ and the recognition ‘that life, after all, is worth while’.⁵

Under Henderson’s direction, modernisations also included the inauguration of a dental department, a surgical operating theatre, a new kitchen, a dining hall, and the ‘reconstitution of certain ward units’. Recognising that ‘physical illness and mental illness often go hand in hand’, Henderson secured the consulting services of a ‘broad range of specialists’,⁶ and for the first time in Gartnavel’s history an honorary consulting staff served the hospital whose expertise spanned ‘medicine, surgery, ophthalmology, ear, nose and throat, dermatology and gynaecology’.⁷ Moreover, in close proximity to Gartnavel, ‘research work was encouraged at the Western Asylums Laboratory’, thereby further lessening the mental hospital’s alienation from wider scientific and medical communities.⁸

Alongside the allocation of more therapeutic, surgical, and laboratory facilities, Henderson began more fully to inaugurate Meyerian principles of teaching and record keeping within the institution. ‘The training of medical staff’, wrote Henderson, became centralised around the newly introduced method of the staff meeting (see figure 6). Three mornings

⁴ Henderson ‘Occupational Therapy: A Series of Papers Read at a Meeting of the Scottish Division Held at the Glasgow Royal Mental Hospital on Friday, May 2, 1924’ *The British Journal of Psychiatry* 71 (1925) 59-80. Reprinted in ‘A Reprint of Papers by D. K. Henderson’ GB 812 HB13B/14/40 NHSGGCA p. 64.

⁵ Ibid p. 66. See also Snedden ‘Environment and Architecture’ p. 37. For the numbers of male and female patients admitted between 1921 and 1930 see the tally of male and female admissions in the hospitals *Annual Reports*. GB812 HB13/2/108-117 NHSGGCA.

⁶ ‘I feel very strongly’ wrote Henderson in his contribution to the 1923 *Annual Report* ‘that mental hospitals have lived too isolated an existence’. By bringing into the hospital specialist consultants and modern medical facilities, Henderson felt sure that Gartnavel could ‘look forward to receiving great help and great stimulus from a Consulting Staff’ which would be ‘reflected in the health of the patients’ Henderson ‘Report of the Physician-Superintendent for the Year 1923’ p. 25.

⁷ Smith and Swann ‘Medical Officers and Therapeutics, 1921-1993’ p. 75. See also *The One Hundred and Twelfth Annual Report of the Glasgow Royal Mental Hospital, (Glasgow Royal Asylum) for the Year 1925* HB13/2/112 p. 11.

⁸ The Laboratory, founded in 1909 as the Scottish Western Asylums Research Institute, worked in cooperation with the University of Glasgow and was based in Gartnavel. Gartnavel case note records evidence that it was here that patients’ blood, faecal, cerebro-spinal fluid and post mortem samples were analysed, with scientists working to identify the presence of illness or infection such as syphilis. See Henderson *The Evolution of Psychiatry in Scotland* p. 217.

weekly newly admitted patients were presented to, and then discussed by, Gartnavel's staff within a conference room environment.⁹ Staff meetings were comprised three, four, sometimes five medical officers, alongside occupational therapy, nursing and consultant staff, and a single recording stenographer. Across the decade some of the most prominent contributors to the conference proceedings were Drs. A. G. W. Thomson, Dugald Baird, James Skottowe, Mary Knight and Angus MacNiven, alongside occupational therapists Miss Dorothea Robertson and later Miss Annie Melrose, clinical clerks such as Hugh Bankhead and Duncan MacPherson, and in 1923 Dr Whitelaw, director of the Western Asylums Laboratory, became a member of the consultant staff.

Further aligning with the methods of Meyer, the old, cumbersome, leather bound patient registers were substituted for individual case note files that could easily be transported around the wards (see figure 6).¹⁰ Classification of mental diseases was brought up to modern standards as Gartnavel's resident medical officers were encouraged to embrace the disciplined clinical teaching of Kraepelin, the personality studies of Meyer, Hoch and Amsden, and the 'stimulating' work of Freud, Jung and others, while case note taking procedures were revised according to Meyer's psychobiological principles.¹¹ By standardising case taking procedures and modernising classificatory schemes, Gartnavel's clinical activities came to revolve around the case note record's construction. Case taking, examinations, staff conferences, nursing reports, laboratory testing, diagnosis and prognosis; each formed a constituent element of the case note record.¹² The innermost workings of Gartnavel's clinical activities were shaped by the formulaic standards of record keeping demanded by Meyer, and such records yield rich insights into the practical application of dynamic psychiatry at Gartnavel.

Through the use of contemporary printed guides produced by Meyer (1918), Kirby (1921)¹³ and Henderson and Gillespie (1927), each of whom endorsed the method of case

⁹ D. K. Henderson 'Report of the Physician-Superintendent for the Year 1921' *The One Hundred and Eighth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) For the Year 1921* GB 812 HB13/2/108NHSGGCA p. 20.

¹⁰ Ibid.

¹¹ Henderson *The Evolution of Psychiatry in Scotland* pp. 196, 216-17.

¹² As Lamb makes clear, the case note record was the 'object of study' par excellence, as the record 'objectified experience and embodied medical authority and scientific precision'. Lamb *Pathologist of the Mind* p. 169.

¹³ In 1921, the publication of Kirby's *Guides for History Taking* laid out the principles set by Adolf Meyer for the psychobiological analysis of psychiatric patients, and it is from this published guide that the methods employed by Henderson to case note taking in the early 1920s may best be understood. Kirkby, whose professional career was deeply entangled with that of Meyer, was instrumental in personally

note taking originally formulated by Meyer at the New York State Hospital, it is possible to deconstruct the essential structural components that ran throughout patient case note records. By cross-referencing these three published clinical guides, I argue that the dynamic case note record utilised at Gartnavel was principally constructed along Meyerian lines. Moreover, as Henderson followed the guide laid out by Meyer (subsequently updated and published by Kirby), in which the case note record consisted of the ‘The Anamnesis’, ‘The Personality’ ‘The Physical Examination’ and ‘The Mental Examination’, these records offer a unique insight into one of the earliest applications of Meyer’s psychobiological method within a Scottish mental hospital.

In addition to this simple correlation between Meyer’s psychobiology and its application at Gartnavel, case note records evidence how Henderson tailored Meyer’s teachings to his own specifications. In 1929 Meyer wrote to congratulate Henderson on the second edition of his *Text-Book* and began by applauding Henderson’s ‘courage’ to make the ‘case note material’ a central component to the text. ‘You are so much freer from the obsequious acceptance of Kraepelinian terminology’, commented Meyer, but it is evident that Henderson’s *Text-Book* not entirely conformed with his mentors’ teachings, and Meyer found himself ‘a little taken aback by the largely Freudian resume of psychopathology’.¹⁴ Dr Oskar Diethelm, a protégé of Meyer,¹⁵ also reviewed the *Text-Book*. Stating: ‘when we turn to the chapters on general psychopathology and psychoneuroses, the authors present their personal viewpoint, a viewpoint which is different from the Phipps school’,¹⁶ these letters tellingly suggest Henderson held a number of theoretical standpoints that distanced his practice of psychiatry from that of the Phipps School.

It is from sources such as Henderson and Gillespie’s *Text-Book* and the *Annual Reports* of Gartnavel that scholars have so far gained an appreciation of the classificatory systems, the examinatory techniques and the administrative devices used by Henderson within

demonstrating to Henderson Meyer’s psychobiological approach to clinical study. In 1908 Henderson worked as a junior staff member under Kirby within the New York State Psychiatric Institute, and almost two decades later it was from Kirby’s guide book that Henderson took inspiration for his own published account of the examination and recording methods that should be applied to psychiatric patients.

¹⁴ Individual Correspondence Henderson, Dated 20th June 1929, Series I – Correspondence, Box no I/1659/13 AMC.

¹⁵ George J. Makari and Robert Michels ‘Oscar Diethelm, M.D., 1897-1993’ *American Journal of Psychiatry* Vol 160, 6 (2003) 1060-1060.

¹⁶ Individual Correspondence, Diethelm to Henderson, Dated 28th June 1929, Series I – Correspondence, Box no I/1659/13 AMC.

Gartnavel during the 1920s. Yet before 1927 there is no simple formula, no text-book, which lays down the precise methods used by Henderson to formulate his approach to dynamic psychiatry. Upon his ascension to Physician-Superintendent in 1921, Henderson's approach to the care and study of mental illness was pioneering, but still in many ways embryonic. Having trained in Britain, North America and Germany, Henderson's dynamic principles were founded upon a range of distinct, sometimes conflicting medical models, and his early publications suggest that he was continually reforming and devising his own application of dynamic psychiatry.¹⁷ By interspersing an analysis of Henderson, Meyer and Kirby's guides for examination with excerpts taken from case note records of the anamnesis (family, personal and present history) and of the mental and physical examinations, the following three chapters contrast the ideological, with the practical application of dynamic psychiatry within Gartnavel.

Before turning to such explorations, however, this chapter addresses some of the more pressing methodological issues that arise from the use of case note records. By presenting, in tabulated and pictorial form, an 'anatomy' of the archival sources used in the thesis, I discuss the methodological approaches that structure my selection, interpretation and reproduction of the patient case note records used within this study.

Sampling approach

In order for analysis to penetrate the innermost workings of the dynamic approach as it structured clinical encounters, 63 patient case note records were selected for analysis from a total of 1389 patients admitted to Gartnavel between 1921-1930. These case note records, representing 1/22nd of total admissions over the nine year period, were individually photographed and categorised, with basic cataloguing information such as name, age, sex and diagnosis being indexed alongside a more-in depth qualitative analysis of the social and clinical specificities of each case. While attempting to identify a range of clinical diagnoses so as to demonstrate the array of psychological and organic disorders identified as present within the hospital, selection was predominantly geared towards case note records that preserved the richest and most comprehensive sets of data. With case note records being made up of medical certificates, nursing reports, examination records and on occasion staff meeting transcriptions and articles of correspondence, such records enable a

¹⁷ For examples of Henderson's early published papers see 'Remarks on Cases Received in the Henry Phipps Psychiatric Clinic' - 'Catatonia as a Type of Mental Reaction' *The British Journal of Psychiatry* 62 (1916) 556-572. - 'Occupational Therapy'.

multifaceted analysis of the complex relations that bound patients to practitioners within the clinical encounter. They reveal a vast array of personal stories and clinical processes which demonstrate the truly subjective, ever-changing nature of patient experiences, hospital practices and psychiatric thought. But of course, such a selective process inevitably prioritises cases deemed most interesting by psychiatrists, whose attendance in the hospital was long enough for the creation of a detailed case note record, or, in the case of staff meetings, those meetings leading to the most vocal and articulate debates.¹⁸

Staff meeting transcripts, in particular, are largely representative of a select group of patient, for not *all* patient case note records included a staff meeting transcript. Only three out of the first 100 patients, admitted to Gartnavel in 1921 after Henderson introduced single patient case files, retain staff meeting transcripts. Five out of 100 patients classified as case nos. 600-700 - who were mostly admitted 1926-1927 - evidence staff meeting transcripts, and therefore a high proportion of these cases are included in the sample.¹⁹ Henderson records that almost every patient was brought into a staff meeting soon after their arrival, and it therefore unclear why only a handful of transcripts were retained.²⁰ In an attempt to counterbalance the partiality of such sources, the following chapters are interspersed with quotations taken from case note records which - because of the short length of the patient's stay in the hospital, the severe organic and therefore debilitating state of their illness, or the loss of certain documentary sources - offer one-sided or incomplete, yet differentially illuminating insights into the clinical encounter.

Anatomy of the archives

To give an overall impression of this selective archive of 63 case note records, the following table provides an outline of the cases used here. This tabulated representation of these archival materials is followed by a set of photographs taken of a medical certificate, two case note records and two staff meeting transcripts. By presenting these sources in their original layout, complete with typed and hand-written sections, overlaid with comments, revisions and deletions - which in turn reveal much as to the temporal, physical

¹⁸ Patient correspondence which were either seen by the asylum staff to demonstrate a patient's disordered state of mind, or which were deemed offensive or damaging to either patient or recipient, thematically outweigh other forms of correspondence in the sample of 63 patient case notes taken. For a comparative analysis of patient letters see Allan Beveridge 'Voices of the mad patients' letters from the Royal Edinburgh Asylum, 1873-1908' *Psychological Medicine*, (1997) 27, p. 900.

¹⁹ For a full online catalogue of patient cases and the contents of their files see: <http://archiveshub.ac.uk/data/gb812-hb13> [accessed throughout 2013-April 2014].

²⁰ Henderson 'Report of the Physician-Superintendent for the Year 1921' p. 20.

and spatial construction of these records - I move on to a discussion of some of the significant methodological and interpretative issues which accompany these sources.

Table 2. Showing the sample of 63 patients used in this study, taken from the Records of Gartnavel Royal Hospital, Glasgow, GB 812 HB13, NHSGGCA.

Ref Code	Pseudo name	Admission	Discharge/ Death	Diagnosis
HB13/5/182/40	Helen Davidson	Nov 1924	Feb 1926	Paranoid Praecox
HB13/5/186/70	Richard Govan	Nov 1927	Oct 1928	G.P.I.
HB13/5/185/18	Margaret Gray	Mar 1925	Nov 1926	Unknown
HB13/5/182/2	Walter Parson	Aug 1923	Mar 1924	G.P.I.
HB13/5/185/19	Andrew Weir	Aug 1925	Aug 1927	Organic Brain Disease
HB13/5/181/2	Percy Williams	Oct 1925	Jan 1925	Psychasthenia
HB13/5/185/8	Peter Richards	Mar 1927	Jun 1927	Unknown
HB13/5/182/4	Archibald Adams	Jul 1923	Nov 1925	Involuntional Melancholia
HB13/5/184/60	Catherine Lockhart	April 1926	May 1927	Manic Depression
HB13/5/179/42	Robert Donaldson	May 1923	Aug 1923	Dementia Praecox
HB13/5/181/36	Harriet Paterson	Nov 1924	April 1925	Manic Depression
HB13/5/187/55	Marjorie Fullerton	Dec 1928	Mar 1929	Schizophrenia
HB13/5/189/21	Patrick Johnstone	July 1930	July 1930	Unknown
HB13/5/182/12	Duncan Barrowman	Nov 1924	Dec 1925	Psychoneurotic State
HB13/5/182/11	George Armstrong	Nov 1925	Dec 1925	Manic Depression
HB13/5/182/7	Patricia Robb	May 1925	Aug 1925	Paraphrenia
HB13/5/189/34	Annabel Brown	Mar 1930	June 1930	Schizophrenia Simplex
HB13/5/187/56	Mildred Marston	Jul 1924	Apr 1929	Schizophrenia Paranoid
HB13/5/182/9	Dora MacLeod	Feb 1925	Sept 1925	Paranoia
HB13/5/184/47	Mary White	Sept 1926	Mar 1927	G.P.I.
HB13/5/185/31	Beryl Latham	Dec 1925	Jun 1927	Mental Deficiency and Hysteria
HB13/4/147, readmitted HB13/5/187/43	Edmund Williamson	Jul 1920 Feb 1929	Jan 1921 Mar 1929	Manic Depressive
HB13/5/184/23	Harriet Smith	Sep 1924	Dec 1926	Anxiety Neurosis
HB13/5/176	Margaret Beaton	May 1921	July 1933	Moral Deficiency
HB13/5/183/54	Robert Norton	July 1926	Nov 1926	Schizophrenic Episode
HB13/5/181/53	Douglas Aitken	Feb 1924	Oct 1925	Organic Brain Disease (G.P.I)
HB13/5/181/50	Thomas McVail	Apr 1924	Aug 1925	Dementia Praecox
HB13/5/184/22	Martha Little	Oct 1925	Feb 1927	Unknown
HB13/5/189/19	Agnes Sneddon	Oct 1926	Jul 1930	Dementia Praecox Paranoid
HB13/5/184/45	Charlotte Bennie	Oct 1926	Apr 1927	Morphine Addiction

HB13/5/187/54	Charles Close	Arp 1929	Arp 1929	Schizophrenia Paranoid
HB13/5/187/90	Charlotte Keir	Jul 1929	Aug 1929	Schizophrenic Episode
HB13/5/189/29	Beryl Patterson	Nov 1924	Mar 1925	Paraphrenia
HB13/5/182/33	Donald Knight	Dec 1924	May 1936	Paranoid State
HB13/5/179/23	Walter Hendry	Feb 1923	May 1923	G.P.I.
HB13/5/181/49	Edmund Flannagan	Mar 1925	May 1925	Traumatic State with Complicating features
HB13/5/185/32	Jane Brown	Dec 1926	Aug 1927	Alcohol Addiction
HB13/5/185/3	Jessie McBride	Mar 1926	Jun 1927	Presbyophrenia
HB13/5/179/28	James Conry	Nov 1922	Jun 1923	Neurasthenia
HB13/5/181/37	Ernest Barnes	Jan 1925	Jun 1925	Dementia Praecox Reaction Type
HB13/5/187/31	Jamie Crawford	Jul 1925	Jan 1929	Manic Depressive Schizoid
HB13/5/179/34	Rosemary Macfarlane	Dec 1922	Feb 1926	Paraphrenia with Dementia Praecox Paranoid
HB13/5/179/32	Jeannie Gove	June 1923 Apr 1925	Sep 1923 Jul 1925	Manic Depressive
HB13/5/179/30	Bridget McNab	Apr 1923	Jul 1923	Involitional Melancholia
HB13/5/182/20	Jeanie McGover	Sep 1923	Jan 1926	Unknown
HB13/5/180/69	Henry Holmes	Jul 1922	Oct 1924	Traumatic State with Epileptoid Syndrome
HB13/5/179/55	Mary Noble	May 1923	Dec 1923	Toxic Exhaustive
HB13/5/182/28	Molly Black	Feb 1925	Oct 1925	Involitional Melancholia, Anxiety State
HB13/5/184/6	Sandy McFarlane	Jan 1926	Apr 1935	Unknown
HB13/5/185/46	Isabella Crawford	Jan 1923	Sep 1927	Involitional Melancholia
HB13/5/182/41	Annabella Smith	Dec 1925	Mar 1926	Schizophrenia, Psychoneurotic Features
HB13/5/181/21	Hannah Duncan	Mar 1925	Apr 1925	Organic Brain Disease
HB13/5/147	Fraser Mackenzie	Oct 1920	Apr 1921	Psychoneurosis
HB13/5/183/45	Barbara Woof	June 1926	Oct 1926	Unknown
HB13/5/192/47	Hannah Matthews	Jan 1929	Oct 1934	Reactive Depression
HB13/5/187/80	Jeanie O'Brian	Apr 1923	Jun 1929	Unknown
HB13/6/80	Elizabeth Gordon	Aug 1926	May 1956	Dementia Praecox
HB13/5/184/49	Abigail Knightly	Oct 1925	Dec 1927	Unknown
HB13/5/184/36	Mary Smith	Jul 1924	Mar 1927	Dementia praecox paranoid
HB13/5/187/17	Mary Crawford	Jan 1924	Jan 1929	Hallucinatory Paranoia
HB13/5/185/26	Margaret Lyle	May 1925	Jul 1927	Manic Depressive
HB13/5/176	Margaret Beaton	May 1921	Jul 1933	Constitutional inferior: Moral Defect

Figure 7.1. Sample pages showing the Petition and Certificates of Insanity, Admission Documents, male and female c. 1929 GB 812 HB13/7/136 NMSGCA.

No. 1.
[FORM A.]

25 & 26 Vict. Cap. 54, Sect. 14.

PETITION TO THE SHERIFF TO GRANT ORDER FOR THE
RECEPTION OF A PATIENT INTO AN ASYLUM.

Unto the Honourable the (1) Sheriff of the (2) Shire of Yanack and his Substitutes,—

The Petition of [redacted] humbly sheweth that it appears from the subjoined Statement and accompanying Medical Certificates, that your Petitioner's (3) [redacted] daughter is at present in a state of Mental Derangement, and a proper person for treatment in an Asylum for the Insane. May it therefore please your Lordship to authorize the transmission of the said [redacted] to the Glasgow Royal Asylum and to sanction her admission into the said Asylum.

(To be signed by the Party applying) [Signature]

DATED this 14th day of August One thousand nine hundred and 26

(4) The date of the Petition must be within fourteen clear days following the dates of the Medical Certificates.

STATEMENT.

If any of the Particulars in this Statement be not known the fact to be so stated

1. Christian Name and Surname of Patient at length,	[redacted]
2. Sex and Age,	Female 33 years
3. Married, Single or Widowed,	Single
4. Condition of Life, and previous Occupation (if any),	Housewife
5. Religious Persuasion, so far as known,	Protestant
6. Previous Place of Abode,	Residence B. w. w.
7. Place where Found and Examined,	Residence B. w. w. and Glasgow Royal Asylum
8. Length of time Insane,	18 months
9. Whether first Attack,	Yes
10. Age (if known) on first Attack,	31 years
11. When and where previously under Examination and Treatment (5),	Nowhere
12. Duration of existing Attack,	18 months
13. Supposed Cause,	Badly ill health
14. Whether subject to Epilepsy,	No
15. Whether Suicidal,	No
16. Whether Dangerous to others,	No
17. Parish or Union to which the Lunatic (if a Pauper) is Chargeable,	Not chargeable
18. Christian Name and Surname, and Place of Abode of nearest known Relative of the Patient, and degree of Relationship (if known), and whether any member of Family known to be or to have been Insane,	[redacted] Mother two sisters and a brother
19. Special circumstances (if any) preventing the insertion of any of the above particulars,	None

I certify that to the best of my knowledge, the above particulars are correctly stated.

DATED this 14th day of August One thousand nine hundred and 26

(To be signed by the Party applying) [redacted]

EDINBURGH
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.
To be purchased through any Bookseller or directly from H.M. STATIONERY OFFICE, 25 FORTH STREET, EDINBURGH.

Figure 7.2

MEDICAL CERTIFICATE No. I.

(1) Set forth the qualification entitling the person certifying to grant the Certificate: e.g. Member of the Royal College of Physicians in Edinburgh.

I, the undersigned, John Anderson being a (1) Bachelor of Medicine and Surgery (Glasgow University) and being in actual practice as a (2) Physician do hereby certify, on soul and conscience, that I have this day, at (3) [redacted] in the County of [redacted] separately from any other Medical Practitioner, visited and personally examined (4) [redacted] and that the said [redacted] is a (5) person of unsound mind and a proper person to be detained under Care and Treatment, and that I have formed this opinion upon the following grounds, viz:—

(6) State the facts.

1. Facts indicating Insanity observed by myself: (6) She is obsessed with the idea that she is an important member of the Navy League and that she has secrets only to be divulged to the officials of that league. She is highly excitable and suspicious of the other inmates of the house.

(7) State the information and from whom derived.

2. Other facts (if any) indicating Insanity communicated to me by others: (7) From her mother the information is given that they have no control over her. She gets out of the windows and calls on neighbours at all hours asking for advice on astronomical matters.

Name and Medical Designation: John Anderson M.B. Ch.B.
 Place of Abode: Arusbray, Clarks in Glasgow

DATED this Thirtieth day of August One thousand nine hundred and twenty six

MEDICAL CERTIFICATE No. II.

(1) Set forth the qualification entitling the person certifying to grant the Certificate: e.g. Member of the Royal College of Physicians in Edinburgh.

I, the undersigned, George Pearson being a (1) Bachelor of Medicine and Surgery of Glasgow University and being in actual practice as a (2) Physician do hereby certify, on soul and conscience, that I have this day, at (3) The Glasgow Royal Asylum in the County of [redacted] separately from any other Medical Practitioner, visited and personally examined (4) [redacted] and that the said [redacted] is a (5) person of unsound mind and a proper person to be detained under Care and Treatment, and that I have formed this opinion upon the following grounds, viz:—

(6) State the facts.

1. Facts indicating Insanity observed by myself: (6) She is suffering from delusions of grandeur and persecution. She believes she held the rank of a Vice Admiral during the war & was a person of great importance. She is very suspicious of her neighbours who are jealous of her power. She is childish in her behaviour and makes foolish communications to the Press.

(7) State the information and from whom derived.

2. Other facts (if any) indicating Insanity communicated to me by others: (7) Her mother informs me she believes she was chosen through the streets of Glasgow which is not a fact.

Name and Medical Designation: G. Pearson M.B. Ch.B.
 Place of Abode: 5 Torrington Terrace

DATED this fourteenth day of August One thousand nine hundred and twenty six

Figure 8.1. Sample pages showing 'Certificates' 'Family History' 'Physical Examination' and 'Mental Examination' notes, in Gartnavel Asylum Case Note Records c. 1924, Case No 330 GB812 HB13/5/182/40 NHSGGCA.

[REDACTED] Admitted [REDACTED] Nov. 1924.
Single Age 45. Occupation. Housewife.
Address. [REDACTED] Glasgow.
Length of time insane, Two months. First attack.
Supposed cause, Change of life and worry.
Not epileptic, not suicidal, and not dangerous to others.
Surety and nearest relative. [REDACTED] (uncle?)
[REDACTED] Sister. [REDACTED]
[REDACTED]

Certificates.

1. Patient is suffering from delusions. She seems to be of opinion that I have injured some friend of hers and in some way and that I am going to do her an injury. Also says she is going to have a child this fact having been revealed to her in a vision.
Her friends say that she is under the impression that they are trying to murder her and that she has been summoned to Rome as she has a vision naming her as a second Virgin Mary.
Dr. McGorrie, 181 Queens Drive, Glasgow.

11. Patient is suffering from delusions and is of opinion that her friends and others are trying to murder her.
Her friends state that patient thinks that her friends are trying to murder her and that she has had a vision and is going to see the Pope concerning it.

Family History. from sister.
Her father died aged 64 of arterial disease.
Her mother is a patient in this hospital where she has been for

Figure 8.2. Case No 330 GB812 HB13/5/182/40 NHSGGCA.

a message had been sent to her telling her to go to Rome on Monday 1st. Dec. She said the neighbours were plotting to kill her, and when the doctor came to examine her she was afraid that she was to be killed. The informant stated that she thought her sister had auditory hallucinations but she cannot give any evidence of visions. Since the commencement of her illness the patient has carried on her housework as usual. She has not been sleeping well and her appetite has been poor.

On Admission.

When seen in the reception room the patient was sitting on the couch leaning heavily upon her sister's shoulder. Her eyes were closed and when she was spoken to she refused to answer or indicate in any way that she had heard the question. After an interval however she sat up and opened her eyes and in reply to the question "How are you?", she said "Don't be silly" She seemed quite composed but annoyed and very impatient at any questions asked her. She said "Leave me alone, Take me away and kill me and be done with it."

She was very unwilling to give any account of herself or her trouble. She went quietly with nurse to the ward.

Physical Condition.

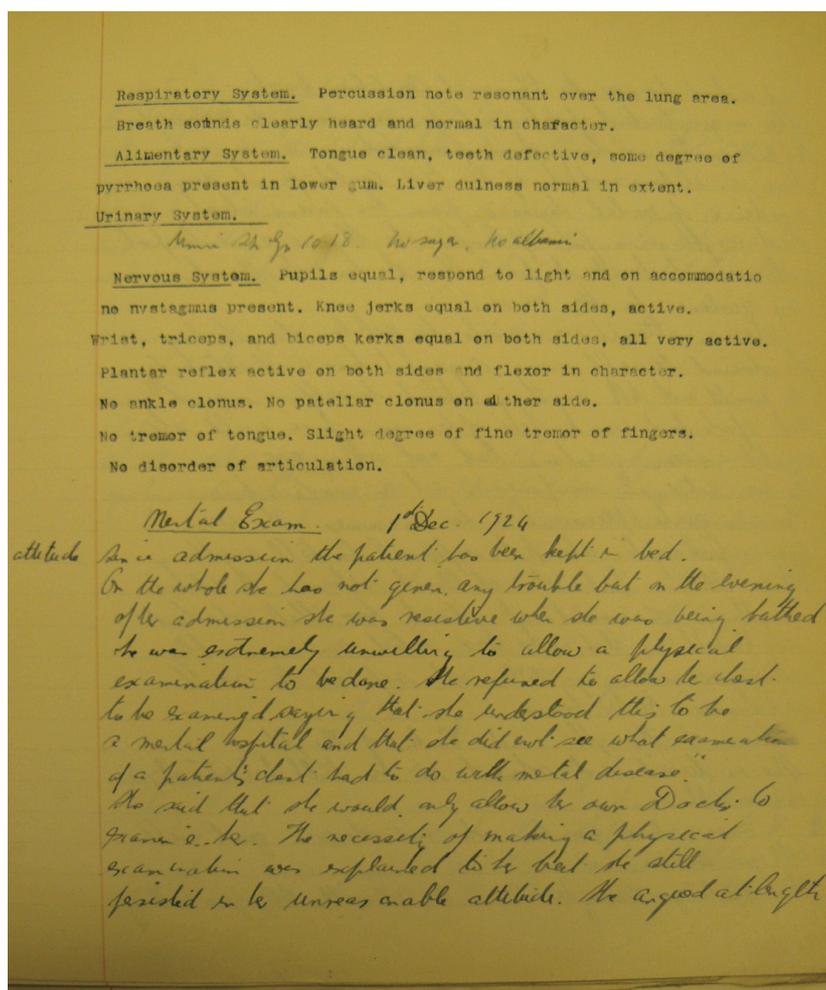
She did not cooperate well in the physical examination. She was unwilling to allow it to be done.

She is well nourished and of good colour.

Cardiac System. The area of cardiac dullness is normal in extent.

The heart sounds are pure and of good quality. Pulse, Rate 80 regular in force and rhythm. No thickening of arterial walls.

B.P. 150mmHg. systolic and 75mm Hg. diastolic.



²¹ Respiratory System. Percussion not resonant over the lung area. Breath sounds clearly hard and normal in character.

Alimentary System. Tongue clean, teeth defective, some degree of pyrrhoea present in lower gum. Liver dullness normal in extent.

Urinary System.

Mini Sp Gr 1018 No sugar. No allumi [unsure of precise wording here]

Nervous System. Pupils equal, respond to light and on accommodation no nystagmus present. Knee jerks equal on both sides, active. Wrist, triceps, and biceps kerks equal on both sides, all very active. Plantar reflex active on both sides and flexor in character. No ankle clonus. No patellar clonus on either side. No tremor of tongue. Slight degree of fine tremor of fingers. No disorder of articulation.

Mental Exam. 1st Dec 1924

attitude Since admission the patient has been kept in bed. On the whole she has not given any trouble but on the evening of her admission she was resistive when she was being bathed. She was extremely unwilling to allow a physical examination to be done. She refused to allow the chest to be examined saying that she understood this to be a mental hospital and that she did not see what examination of a patient's chest had to do with mental disease." She said she would only allow her own Doctor to examine her. The necessity of making a physical examination was explained to her but she still persisted in her unreasonable attitude. She agreed at length ...

Fig 8.4. Case no 612, GB812 HB13/5/187/12 NHSGGCA.

Restless
Examination : April 1927 .
General Behaviour .
Is still very restless and getting out of bed a great deal ; but is reported by attendants to answer ~~more~~ simple questions better , and is biddable . He is sleeping well , once he gets off to sleep . Taking his food well , and no longer requires to be spoon-fed . Takes food quite neatly . Cleanly in habits.
*Answered better
is biddable
sleeps well.*
*Takes food neatly
clean habits*

Stream of Activity .
"Took notice" When the M.O. came in he sat up in an interested fashion , and watched M.O. ; but he did not say anything .
*Find to concentrate
Must in future* When spoken to he replied sometimes to the point and sometimes not . His attention tended to drift from the topic , and he continued in a rambling series of remarks . He showed little evidence of distractability ,
not distractable the drifting of his conversation being determined apparently by internal associations .

M.O. How are you ?
Pat: Oh, I thought you were talking to me -- about stuff returned -- oh , I'm all right . Oh, I thought it ..was me.. all right . (He lay back in bed and stopped talking)
M.O. How are you feeling ?
Pat: Not too fit .. I'm ..ready (possibly "headache" ; he put up his left hand to his head and kept it there a moment .) I've lost my tongue ; may come again ...but I'll

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Figure 9.2. Sample pages from Staff Meeting Transcript, Gartnavel Asylum Case Note Records, showing debate between staff, c. 1925, Case notes no 302 GB 812 HB13/5/182/12.

7

Dr. Thomson. "And he himself says he has never been well".

Dr. Whitelaw. "He dates it from the crash. If he was near a fifteen gun going off at the same time as the bomb " -

Dr. Henderson. "We saw a lot of shell-shock concussion, but I must confess I have never seen anything like this, with this type of history"

Dr. Thomson. "The particular thing that is strange is the long delay in which there was a period of very great betterment".

Dr. Whitelaw. "His cerebro-spinal fluid was a little high under pressure".

Dr. Henderson. "I think we should get the eye-grounds examined, and I think, if necessary, (I do not know that it would do any good), we might have an X Ray. examination of his skull".

Dr. MacNiven. "He seems, in speaking, to have some trouble in finding words at times".

Dr. Henderson. "The thing that strikes me - although the anxiety is a feature, back of it. I feel that we are dealing with a man whose brain has been definitely injured in some way; there has been a definite organic process."

Dr. MacNiven. "The nature of his mental symptoms, delusional, stupid conduct, with the memory defect".

Dr. Henderson. "Yes".

Dr. Whitelaw. "You get these blanks in hysteroid things".

Dr. Henderson. "You do, but I do not think you get the lack of insight".

Exploring the dichotomous elements of the case note record

Meyerian guides to history taking, that provided students with the basic outline and order of case taking procedures,²² are significant to the history of Western psychiatry. For throughout the nineteenth and early twentieth century, the very structure of case note taking, argues John D. Stoeckle and Andrew Billings, was rarely laid out in instructional texts.²³ Unlike Gartnavel's case note records, which were structured in close alignment with Meyerian guides, teaching how to conduct examinations and produce case note records was often an oral exercise in Western psychiatry. This thesis is therefore in a privileged position, being able to understand precisely the theoretical frameworks used to construct and interpret them. These guides, presenting in fine-grained detail the procedures for case note records taking, allow for the systematic examination of individual case files. By comparing and contrasting the theoretical construction of the case note record, as laid down in published guides, with the practical construction of the dynamic case note record within Gartnavel, my research may highlight which components of Meyerian case taking were tailored by Henderson, and to question why these alterations occurred.

Nonetheless, while Gartnavel's case note records offer uniformity in style and structure, their analysis is complicated by the subjective nature of the dynamic case note record's construction. As these guides were implemented within tangible hospital settings, functioning to mediate clinical encounters between patients and practitioners, each case is the depiction of an individual life history, observed from numerous subjective standpoints and contextualised within differing temporal and spatial arenas.²⁴ The role of the case note record to produce comparable clinical data is always counterposed by the psychiatrist's need to pay close attention to the phenomenological aspects of mental illness; therefore, when analysing such records, the importance of investigating the subjectivity and individual agency of patients and practitioners is tantamount to the investigation of clinical uniformity.²⁵ Psychiatrists-turned-historians, Ida Macalpine and Richard Hunter, most comprehensively explain why the subjectivity, encased within case note records, may become problematic to the historian.²⁶

²² Leys 'Types of One' pp. 5-6.

²³ Stoeckle and Billings 'A History of History-Taking: The Medical Interview' pp. 119-120.

²⁴ Berkenkotter *Patient Tales* p. 9, 19. See also Andrews 'Case notes, Case Histories' pp. 278-79.

²⁵ Berkenkotter *Patient Tales* p. 4.

²⁶ Ida Macalpine and Richard Hunter *Three Hundred Years of Psychiatry 1535-1860. A History Presented in Selected English Texts* (London: Oxford University Press, 1964) p. vii.

What makes psychiatry so complex is that it belongs both to the natural sciences and the humanities ... It is concerned much less than general medicine with disease entities and processes, but rather with patients and people. Accordingly it is much more exposed to subjective factors ... Case-taking, for instance, which provides psychiatry's basic data, is inseparable from observer influence and error. There is not even an objective method of describing or communicating clinical findings without subjective interpretation and no exact and uniform terminology which conveys precisely the same to all. In consequence there is a wide divergence of diagnosis, even of diagnoses, a steady flow of new terms and an everchanging nomenclature, as well as a surfeit of hypotheses which tend to be presented as fact...²⁷

In light of this statement, I argue that it is precisely because we are dealing with a set of documents so integrally shaped by subjective factors that their historical value lies. On the one hand, we are dealing with sources that replicate the basic structure of Meyerian examinatory and case note taking outlines, furnishing a relatively uniform data set from which to draw comparative analyses. But on the other hand, when we look past such uniformity, we see that each dynamic case note record partakes in the construction of an *individual* patient identity, replete with the personal narratives, unique encounters and interpersonal relations integral to patients' stories, and enriching to psychiatrists' understanding of mental illness. My analysis of dynamic case note records is therefore often torn, fluctuating between the exploration of the personal and particular, and the wider uniformity of their construction. While this does not always make for easy reading, it is arguable that the 'complex', often ambiguous 'relations [that] were going on between doctor and patient, between lay governors and medical staff, and so on', may now only ever be retrieved by the employment of a narrative framework which reverberates between these often oppositional dimensions, embedded within the dynamic case note record.²⁸ The following section details the development of my own interpretive strategies, as I consider precisely how to investigate the somewhat paradoxical elements of the case note record.

Interpretive strategies: authorship, production and reproduction of case note records and staff meeting transcripts

Contemporary hospital case reports are generally written from the point of view of treating physicians in the third person and in the voice of anonymous, effaced

²⁷ Macalpine and Hunter *Three Hundred Years of Psychiatry 1535-1860* p. vii.

²⁸ See Akihito Suzuki 'Framing Psychiatric Subjectivity, Doctor, patient and Record-Keeping at Bethlem in the Nineteenth Century' p. 116. See also Scull *The Insanity of Place/The Place of Insanity* p. 137. Spence 'Narrative Smoothing and Clinical Wisdom' p. 215.

narrators, co-authored by a medical team that betrays little of the differentiated involvements of its contributors. Although traces of the dramatic and curious can still be found in modern cases ... linguistic analysis finds passive sentence construction depicting agentless events and processes to be the discursive norm.²⁹

One of the most remarkable and engaging aspects of Gartnavel's case note records is the first person narratives, not only of patients but also of informants and practitioners, that emerge, full of character and subjective opinion, across the pages of these documents. Unlike many twenty-first century 'case reports' described by Brian Hurwitz, Gartnavel's records attest to the active formation and differing authorial perspectives contributing to their construction. Interspersed among third person narratives of clinical clerks and medical officers - who aimed to record observations of fact - are fragments of first person narratives and quoted speech, thus imparting authorial agency to individual medical officers, clinical clerks, patients and informants. As Meyer laid down the basic outline for case note taking, the act of storytelling was an integral part of the dynamic case note record and therefore traces of the 'dramatic and curious', as well as the ordinary and mundane, may be found among clinical records.

As discussed in chapter two, dynamic psychiatrists placed considerable weight upon the particular use of language and reproduction of the spoken word, as they strove to capture the observable facts of the case. The application of a common sense, everyday language, was envisaged to uphold the objectivity of the writer, while the faithful reproduction of the patient-practitioner dialogue aspired to investigate patient language as a reaction to distinct environmental conditions, including the presence of the medical officer within interviews, rather than to consider patient narratives as straightforwardly reflecting thoughts and feelings.³⁰ Dynamic psychiatrists such as Meyer and Henderson went to considerable lengths to reproduce a faithful account of clinical events. But how far do these textual sources represent the reality they pertain to capture? As Chris Philo and Cheryl McGeachan remark, '[w]ords are both crucially *reflective* of the goings-on in the human world, but also unavoidably *generative* of that world', and therefore one must explore how mediums of knowledge production, such as clinical clerks and stenographers, not only record but also reconstruct and actively shape the discursive happenings of clinical encounters.³¹ Taking heed of the work of Raphael Samuel who writes on the 'Perils of the

²⁹ Hurwitz 'Form and Representation in Clinical Case Reports' pp. 236-7.

³⁰ Kirby *Guides for History Taking* p. 57.

³¹ McGeachan and Philo 'Words' p. 3.

transcript', it is clear that grammatical and lexical choices, made at the time of case note record production, necessarily distort and refract the clinical happenings that were under observation.³²

The spoken word can very easily be mutilated when it is taken down in writing and transferred to the printed page. Some distortion is bound to arise, what ever the intention of the writer, simply by cutting out pauses and repetitions – a concession which writers very generally feel bound to make in the interests of readability... A much more serious distortion arises when the spoken word is boxed into the categories of written prose.³³

The following chapters take into consideration the larger structural frameworks, as laid down in case note taking guides, which shaped case note taking procedures, but at this moment I consider authorial agency. That is, the varying conditions under which pen was put to paper, fingers were placed on typewriter keys, and the act of case note taking and/or transcription was performed. Through the employment of a critical hermeneutics, one that addresses the specific temporal and spatial conditions, as well as the technological and literary devices employed, of the case note record's construction, I question precisely how these mediated representations of clinical encounters were constructed. In doing so, I demonstrate my own interpretive strategies applied to reading these sources.

Case note records – authorial agency and interpretative strategies

Patient records are surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed. Converting complex clinical perceptions of illness into written narratives involves both selection and interpretation; and although intended by clinicians to lay bare the course of illness and therapy, much else is often revealed.³⁴

Turning to the construction of patient case note records, figs 8.1-4 demonstrate that these documents are multi-authored, with statements, taken from medical certificates, family informants, patients, pathological reports and medical officers, collated upon its pages. The purpose of the case note record, explains Gayle Davis, was to compile a single file that

³² Raphael Samuel 'Perils of the Transcript' in *The Oral History Reader* eds. Robert Perks and Alistair Thomson (New York: Routledge, 1998) p. 389.

³³ Ibid.

³⁴ Risse and Warner 'Reconstructing Clinical Activities' p. 190.

gave ‘quickly accessible information about the patient’, with the duty of writing these documents falling to clinical clerks and medical officers.³⁵ The transposition of admission data (such as medical certificates) into the case note record (see fig 8.1), was conducted in an administrative environment by clinical clerks (often with the aid of a typewriter), while further records of mental and physical examinations could be written down by hand upon the ward in close temporal - spatial proximity to the clinical encounters under observation. These examination records, however, could also be revised, restructured or overlaid with additional observations in the hours or the days following the initial clinical encounter, and therefore these records may also be transpositions of earlier clinical notes. I look specifically to the construction of mental examination records and progress reports; documents that recorded medical officers’ interactions with patients upon the wards and dormitories of Gartnavel. Faced with documents that incorporate a patchwork of perspectives and which were produced, revised and used within shifting temporal and spatial arenas, I enquire into how lexical and grammatical choices shaped the dynamic case note record; a document that endeavours, so intently, to present the unadulterated facts, but which must necessarily come under critical scrutiny.

Firstly, when we look to the use of grammar in case note records, we see some of the techniques used when transferring the spoken word to printed/written page. If we consider the above pictured case note records, we see inverted commas are used to denote verbatim recordings of speech, while the use of colons, dashes and questionmarks are the attempt of the writer to highlight pauses, rhythms and silences that punctuate patients’ spoken words. Brackets, used to insert the writer’s own observations of tone, emotional content or actions that accompanied speech, add another layer of interpretive depth to the case note record. For instance, in fig 8.2 we see the distinction being made between recorded speech and the writer’s own observations through the use of inverted commas:

On Admission.

When seen in the reception room the patient was sitting on the couch leaning heavily upon her sisters shoulder ... in reply to the question “how are you”, she said “Don’t be silly”³⁶

³⁵ Davis *The Cruel Madness of Love* p. 28.

³⁶ Case notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

In fig 8.4 the use of dashes and dotted lines show the writer's intent to preserve the pauses and silences that break up the patient's narrative, while bracketed sections demark the writer's own observations from the narrative of the patient:

M.O. How are you?

Pat: Oh, I thought you were talking to me – about stuff returned – oh. I'm all right. Oh, I thought it ... was me ... all right. (He lay back in his bed and stopped talking)

M.O. How are you feeling?

Pat: Not too fit ... I'm ... heady ...

These grammatical forms, while revealing something of the tempo and rhythm of speech, are not reproduced uniformly throughout patient case note records, while they are prone to inconsistencies in punctuation. My approach has been to replicate, as far as possible, the original layout, as well as any errors or inconsistencies that appear within the original sources. By retaining these inconsistencies and highlighting the revisions, deletions and insertions, I aim to retain those differing layers of authorial agency which show the process of case note construction to be a fluid, unstable and collaborative process. This method, which alters the contents of original sources only in that I condense and therefore insert '...' to the text, removes the need for my insertion of the indicatory [sic] sign, therefore placing the responsibility of grammatical interpretation somewhat upon the reader. It is hoped that by retaining these errors, omissions and inconsistencies that, whatever may be lost in clarity, is made up for in integrity to the original composition of these richly multi-layered texts.

When considering the production of such records, it can also be useful to distinguish between records produced at the time of the clinical encounter and those offering a more retrospective and revised narrative. 'Notes must be written down at the time of observation' was the unequivocal teaching of Meyer, but, as '[t]he writing is usually done with a certain haste and carelessness of handwriting', it became 'very desirable to have the notes typewritten'.³⁷ One of the clearest boundaries between temporal, and sometimes authorial, change is marked in fig 8.3 as the neat typeset of a revised document changes to the handwritten record. Case note records, wrote Meyer, 'should be near the patient and of easy access whenever new notes are added', and therefore handwritten sections may attest to their being produced in close proximity to the clinical encounter. While the old, bulky,

³⁷ Ibid.

patient case note books of Oswald's superintendence were replaced by Henderson with the new, single file case note record, the ease with which they could be transported around the wards gave more opportunity for the production of records at the patient's bedside.³⁸

When considering the temporal sequencing of case note production, the spatial context in which these records were produced may also be a significant variable. One example of multiple authors producing and revising case notes in differing spaces of the institution is the record of a mental examination, carried out on male patient, Douglas Aitken, in 1924. Mr Aitken was recorded as having objected to the close proximity of the medical officer and clinical clerk within the mental examination, stating: 'How am I going to do anything with one of you sitting on my bed, the other standing by looking at me'. During the interview Aitken pointed out to the medical officer:

“You stand with your foot on the bed. I'll not answer another word.” The M.O. had indeed been standing taking notes with one foot on the frame of the bed and without any warning the patient aimed a very vigorous kick at it.³⁹

Here we have the presence of three significant authors: the M.O. (medical officer) sitting on the bed directing the examination and taking notes; the patient counterpoising the direction of the conversation; and the clinical clerk standing by observing the scene, who, it seems, was also the author who put pen to paper and combined the M.O.'s notes with his own observations. It could, of course, have been the M.O. writing in the third person who compiled the final record, but as M.O.s - Henderson in particular - often wrote from the first person perspective, it is likely that it is from the perspective of the clinical clerk that we learn of this particular mental examination.

When attempting to gauge whether hand written case notes are the original notes made upon the ward or a neat revision, this is sometimes made perfectly clear by the author. In the case of Mrs Abigail Knightly, admitted in 1927, it was written in her case note records that:

The notes which follow are written up from pencil ones which were made at the time of the interview, and have been re-arranged to some extent to give the account a better sequence.⁴⁰

³⁸ Meyer 'A Few Remarks Concerning the Organization of the Medical Work in Large Hospitals for the Insane' p. 86.

³⁹ Case no 285 GB812 HB13/5/181/53 NHSGGCA.

Moreover, as demonstrated in Fig 8.4, typewritten documents may be overlaid with handwritten comments indicating that corrections and additional notes were made to documents that had already undergone revision, as they were read and re-interpreted over time. As case note records progress from notes taken in one interview to notes taken several days, weeks or months later, different hand writing styles also attest to the multi-authored construction of case note records. As medical officers and clinical clerks took over the duties of one another, these handwritten passages demonstrate how the case file (and patients themselves) passed through the hands of several medical officers during successive interviews and examinations.

Within case note records, one therefore detects an on-going tension between the preservation of immediate observations and verbatim statements - Meyer's 'positive' facts, which 'stood above or in implicit precedence to any particular interpretation - and the need to insert a degree of order and, indeed, interpretative structuring that distances the reader from the raw happenings of clinical encounters.⁴¹ This tension will be explored more fully in the later chapters.

Staff Meeting – authorial agency and interpretative strategies

Staff meeting records, which were reproduced in the form of verbatim transcriptions, evidence the introduction of new recording technologies and stylistic forms of narrative representation. These transcripts, produced by a trained stenographer, are, in many ways, a more straightforward source of enquiry than the case note record. For instance, they evidence a relatively uniform application of grammar, with the dialogues of patients and medical officers recorded in question and answer form. They are also the product of single typists - rather than a conglomerate of writers - who recorded, word by word, the events of the staff meeting at the time it was conducted. When endeavouring to examine the role played by the stenographer in the production of clinical knowledge, few contemporary sources survive to inform us about their training or the guidelines to which they abided. Gartnavel's *Annual Reports* make no mention of the use of stenographers, and so far only upon one transcript has been found entitled '[C]opy of stenographer's notes made at

⁴⁰ Case notes no 452, GB 182 HB13/5/184/49 NHSGGCA.

⁴¹ Leys 'Types of One' p. 6.

clinical demonstration (by Dr Henderson) 3. 6. 22'.⁴² The role of the stenographer is barely considered in the writings of Meyer⁴³ and not at all by Henderson. The only contemporary source so far found is that of a journal article, from the *American Journal of Psychiatry* in 1937, where the role of the stenographer in the staff meeting (which by then was becoming widely practised in North America due to Meyer's influence and teaching) was given some consideration:

Presumably for the sake of the records a stenographer is present. It is a pity she cannot be made invisible.⁴⁴ Upon the other hand, a clever one can be trained to make running comments and notes upon the patient's responses when these concern solely matters of fact, thus avoiding in part the long series of questions and answers which present such a hopeless array upon many staff conference records. A signal system can be readily devised for informing the stenographer when to make verbatim records, when to summarize and when to make no notes whatever.⁴⁵

The wished for invisibility of the stenographer is, in many ways, a reflection of the stenographer's presence upon the pages of Gartnavel's staff meeting transcripts. Unlike case note records, which intersperse verbatim samples of speech with records dominated by clinical observation, Gartnavel's stenographers leave only the barest of clues upon the transcript as to their authorial agency. Only occasionally do the stenographer's own observations break through into the transcript, to offer summaries of staff member's comments or give brief indications as to the actions and behaviours of patients. It is from these brief asides, however, that we again glean a sense of the pace and tone of the conversation, of the groups and individuals to which certain statements were directed, and of movement and action within these enclosed meeting rooms.

If we look to sections where stenographers summarised sections of dialogue, we see that this was usually done to condense longer statements made by medical officers. As seen in the excerpt below, the third person narrative of the stenographer contrasts sharply with the

⁴² Case notes no 340 GB 812 HB13/5/182/50 NHSGGCA.

⁴³ Meyer 'A Few Remarks Concerning the Organization of the Medical Work in Large Hospitals for the Insane' p. 86. Meyer merely mentions the necessity of employing a stenographer upon the wards and within staff meetings.

⁴⁴ We hear the gendering of roles in North American mental hospitals, with this article presuming that the majority of stenographers were women.

⁴⁵ Charles F. Read 'Clinical Staff Conference' p. 1395. Clarence G. Schultz, writing in 1978 also reveals that Harry Stack Sullivan, a former student of Meyer, used a stenographer within staff conferences in the years 1926 and 1927. Clarence G. Schultz 'Sullivan's Clinical Contribution During the Sheppard Pratt Era - 1923-1930' *Psychiatry* 41 (1978) p. 117.

first person authorial tone of the medical officer, and verbatim samples of speech are clearly distinguished from the stenographer's own summaries.

Q. Do you know what your weight is just now? About how heavy are you?

A. "I was weighed when I was bathed but I don't know what it was. I think it was about eight stone".

(Dr. Henderson emphasised the importance of the frequent weighing of patients, and remarked on the late Sir Thomas Clouston's belief – as expressed in his book – that a beginning increase of weight might be regarded as a sign of improvement).⁴⁶

When looking to the stenographer's use of punctuation and descriptive inserts, we see in the case below that the pace and tempo of the patient's voice is observed, guiding the reader to consider how changes in the delivery of speech may shape the meaning of patient narratives.

Q. Have you been out of the house since you came here?

A. (very slowly and deliberately) I have never been out or downstairs till you took me downstairs to-day. I did not know where I was coming".⁴⁷

Indications are also given to mark those points where dialogue jars, with voices cutting across or over-spilling into one another:

Dr. Henderson. You have spoken about your spine shifting. Do you believe that your spine is –

Patient. (breaking in) Yes I do. When the change comes on it about knocked me off my mind altogether.⁴⁸

Exclamation marks, although used sparingly, most often appear within text that records the speech of Henderson; and, although we cannot be sure of the exact tone or pitch of Henderson's voice, it was evidently raised on a number of occasions:

Patient. "I will investigate that you will be punished for keeping me staying here".

Dr. H. I am perfectly innocent – I have nothing to do with your coming here, you must not punish me !⁴⁹

⁴⁶ Case notes no 331 GB812 HB13/5/182/41 NHSGGCA.

⁴⁷ Case notes no 310 GB812 HB13/5/182/20 NHSGGCA.

⁴⁸ Case notes no 142 GB812 HB13/5/179/42 NHSGGCA.

⁴⁹ Case notes no 310 GB812 HB13/5/182/20 NHSGGCA.

When it comes to the colloquial use of words, stenographers retained the characteristic phrases and mannerisms that marked patients' language, but on occasion a Scots brogue could present too difficult an accent to replicate, with the stenographer evidently imposing a more formal arrangement of a patient's narrative within the transcript:

(This patient spoke with a marked brogue, and in a low voice at times, and it was difficult – indeed impossible – frequently to catch what he said).⁵⁰

Here, more than in any other component of the case note record, the interpretative strategies of the oral historian are well suited to the analysis of the staff meeting transcript. These records, primarily textual but which endeavour to represent the structure, fluidity, tempo and intonations of spoken dialogue, emphasise the subjectivity of the authors, while highlighting the interpersonal relations shaping one another's responses. And, while the mediatory role of the stenographer is recognised, it is the content of the first person dialogue, rather than third person narrative, that is most accessible to the researcher. With language represented in its immediate linguistic context, that is, within a full and unrevised dialogue, I go on to explore the contents of these narratives, not only as statements of fact or opinion, but as statements that react/respond to the content of one another's speech, replete with tone, mannerisms, authority and emotions, as displayed within the staff meeting room.⁵¹

Conclusions

Taking both the case note record and the staff meeting into consideration, it is clear that these documents offer (although to differing degrees) mediated, subjectively constructed, representations of clinical encounters. They demonstrate a strict hierarchy in the production of clinical knowledge, as words filter from the mouths of patients and medical officers down to clinical clerks and stenographers. By investigating the textual clues of authorial agency, left upon the pages of these handwritten and typed documents, we are left with some indication as to differing temporal, spatial and authorial prisms through which we view clinical encounters. If analysis is to penetrate their meaning and situate them within their original contexts, a deep hermeneutic engagement is necessitated. Throughout

⁵⁰ Case notes no 301 GB812 HB13/5/182/11 NHSGGCA.

⁵¹ The importance of analyzing the interactions between interviewer and interviewee can be read in Alessandro Portelli (amongst others) 'The Peculiarities of Oral History' *History Workshop* 12 (1981) 96-107.

the following chapters, which explore the contents of case notes and staff meeting transcripts, it is envisaged that by showing the rough workings of Gartnavel's staff, I can engage with psychiatry in the making. These textual sources, offering such scope for critical engagement will, as Andrew Scull remarks:

[A]llow ... us to explore the actual use and implementation of ... approaches in clinical settings, rather than relying upon the claims and assertions made in the published professional literature ... ⁵²

⁵² Scull *The Insanity of Place/The Place of Insanity* p. 137.

CHAPTER FOUR

GARTNAVEL: CONSTRUCTING DYNAMIC PATIENT CASE NOTE RECORDS

A Text-Book of Psychiatry for Students and Practitioners

An accurate, systematic form of examination is indispensable ... it [is] advisable that the plan suggested below should be followed closely... The plan suggested was first formulated by Dr. Adolf Meyer when he was Director of the Psychiatric Institute, New York. In 1921 Dr. George Kirby edited for the New York State Hospital Commission a series of guides for history-taking and clinical examination, which were largely based on Meyer's original plan. We have followed these closely, but have modified them here and there ... The form of examination which we suggest may be considered under the following headings:

1. Family History
2. Personal History
3. History of the present illness
4. Examination of the patient, including the (a) mental and (b) physical condition.¹

In the summer of 1930, a male attendant accompanied a general practitioner to the house of middle-aged male patient, whose wife, it seems, had requested medical assistance. Upon their arrival the attendant remained outside the patient's front room. After 'much talk and argument' between the doctor and his patient, the attendant was asked to enter the room, where he observed that 'lying near the door on the floor [were] a hatchet and splinters of glass'. 'Softly' laying a hand on the patients arm, the attendant led the patient out of the room, and 'without having to [use] force' they reached the front door of the house. At this point the patient 'made to run away' but the attendant held him back, and, after it was made clear to the patient that his wife would accompany him to Gartnavel, he was finally coerced into the awaiting motorcar. On the way to the hospital the patient sat in silence. On reaching the entrance of Gartnavel, however, his demeanour quickly altered. Stepping out of the motorcar he alighted the steps to the front door, and with a rapidity of pace walked briskly into the male reception hall. Gartnavel's staff observed he then stopped, pausing in order to light his pipe, but after having caught sight of one of the medical officers he 'strode forward', 'cordially' offering his greetings to the 'M.O.', whilst stating his pleasure

¹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 66-88.

at meeting him.² It is at this point, when patient and practitioner meet upon the very threshold of the hospital, that the construction of a patient's case note record begins.

This chapter undertakes an analysis of those first few days in which a patient's case began to be constructed, and their life within the hospital began. This period of transition was, above all other moments in the career of a hospital patient, recorded with a degree of assiduity that is rarely surpassed in subsequent progress notes and therefore demands considerable attention. By interspersing an analysis of Henderson, Meyer and Kirby's guides for examination, with excerpts taken from case note records of the anamnesis (family, personal and present history) and of the mental and physical examinations, this chapter contrasts the ideological, with the practical application of dynamic psychiatry within Gartnavel. By unearthing a 'history from below', so to speak, of psychiatric practice as recorded in case note records, this chapter traces the development of Henderson's distinct, sometimes diffuse array of methods and practices from within clinical encounters.³

When reflecting upon the structure of this chapter it becomes clear that its division into three sections: 'anamnesis', 'physical' and 'mental' examinations, is necessarily counterintuitive to the philosophies of psychobiology. Excerpts, taken from individual patient cases, which furnish these sections, are viewed in alienation of the entire case note record in which they were originally set, and thus deprives the reader from fully appreciating Henderson's employment of a unifying interpretive framework, from which to study the 'whole' patient, reacting to their social and biological environment. Nonetheless, by breaking down the case note record to its constitutive parts, my intention is to highlight 'key facets' of Henderson's dynamic psychiatry before going on to 'understand its complexity as a whole'.⁴ In doing so this enables me to then steer a meaningful path through the analysis of a single patient case in chapter eight, which, as I argue, demonstrates the significance of Henderson's dynamic case note records to histories of psychiatry and mental illness.

² The entrance of the patient to Gartnavel was recorded by a male attendant whose report was inserted within the corresponding Case notes no 777 GB 812 HB13/5/189/21 NHSGGCA.

³ Within the 'Bibliography' of Henderson and Gillespie's *Text-Book of Psychiatry* a condensed list of the principal works cited within the book attest to the vast array of medical practitioners who influenced Henderson's clinical practices.

⁴ Lamb, in structuring her thesis and the proceeding manuscript for her book *Pathologist of the Mind* faced similar structural problems, and her comments helped me appreciate the necessary limitations that are placed upon the analysis of such rich archival sources which, in many ways, defy being broken down into constituent parts. Lamb 'Chapter 2, Mind as Biology: Adolf Meyer's Concept of Psychobiology' in *Pathologist of the Mind* (unpublished manuscript 2014) p. 4.

Part one: the anamnesis

Introduction. In the study of mental cases nothing is more important than a good account of the previous history of the patient, the physical and mental development, and the manner in which the psychosis began. Without this information it will be quite impossible in many cases to understand the nature of the disorder or to make a satisfactory diagnostic grouping of the cases ... In mental cases the practice should be to try always to get the anamnesis from relatives or friends, as in many instances one cannot depend on the patient for the previous history as is usually done in general medical cases.⁵

As demonstrated in figs. 8.1-2 the opening pages of patient case note records begin with the patient's name, age and address being recorded, alongside the supposed cause, aetiology and presenting symptoms of illness. A strict adherence to administrative and legal procedures of the period shaped the initial composure of a patient's medical identity, and therefore these records begin by offering a formulaic collection of data. Two medical certificates, as demonstrated in fig 7.1-2, were legally required for the admission of patients certified insane and therefore these opening pages were often furnished with a copy of these certificatory statements.⁶ Once the patient was brought into contact with Gartnavel's medical officers, however, the case note record turns from an accumulation of administrative data to the construction of a case along dynamic principles.⁷

With Meyer pushing North American psychiatry away from its former emphasis on the 'description of symptoms, classification, and brain pathology', and towards the study of the behaviour of individuals within their total physical and social environment, the anamnesis, which was taken most often from a family informant, became a highly

⁵ Kirby *Guides for History Taking* p. 9.

⁶ The certificatory document consisted of the written testimony of two medical practitioners, a petitioner to the case, and the signature of a local sheriff, which enabled the committal of a patient declared medically insane. The legal prerequisites of certification are laid down in Henderson and Gillespie *Text-Book of Psychiatry* (1932) p. 554.

⁷ The process of certification often occurred at the instigation of patients' families or friends, and therefore in addition to certificatory documents recoding doctors' observations of patients' immediate presenting symptoms, these records often relate information given by patients' friends or family. The certificates in figure 7.1-2 suggest that the degree of influence that friends and relatives had over the certification process was significant, as the doctor's certificate of insanity was only legally binding once a near relative of the patient also signed a petition for the reception of a patient into an asylum. For other examples of the certification document see the Admission Documents: Male and Female HB13/7/128 (1921) NHSGGCA.

significant component of the dynamic case note record.⁸ Although descriptions of patients' most immediate presenting symptoms were provided within certificatory documents, it was family members and close acquaintances who most often bridged the gap between psychiatrists' knowledge of patients studied within clinical encounters, and the history of their behaviours within their former social, work and domestic environments. Indeed, as Henderson and Gillespie wrote, a description of the patient's symptoms was of little 'value' to Gartnavel's psychiatrists 'unless information is collected elsewhere regarding the setting in which the symptoms have occurred and the causes that have been instrumental in producing them'.⁹

Once newly admitted patients were escorted from the reception room, family members or friends - who often accompanied a patient to the hospital - were invited to give a preliminary case history. Unlike in general medicine, the preliminary history (anamnesis) was most often compiled from accounts given by relatives or friends, instead of by the patient. '[I]n many instances' advised Kirby in *Outlines for Psychiatric Examinations* 'one cannot depend on the patient for the previous history'. Rather it was considered that repeated interviews with close family informants provided 'a correct estimate of the family stock and traits' allowing the medical officer 'to get a satisfactory account of the patient's life and mental breakdown'.¹⁰

As I go on to argue, these records may reveal interesting discrepancies between patients' portrayal of their family histories and that of their relatives. Several cases, however, that were included in my sample, reveal that patients could take an active role in the compilation of the anamnesis. George Armstrong, who was accompanied to Gartnavel by his family in 1925, insisted on staying in the room whilst his wife gave the anamnesis. It was noted he 'showed himself to be of great assistance in overcoming his wife's resistance on certain points' and corrected her 'in regards to dates and so fourth'.¹¹ As will be discussed, family informants, as well as patients, were considered a necessary, if not always trustworthy source of investigation.

⁸ As Ruth Leys writes 'For Meyer, psychiatry became the study of the behavior of each person in his or her total social and physical environment. Accordingly, he directed American psychiatry away from its emphasis on the description of symptoms, classification, and brain pathology and toward the study of the personality'. Leys 'Types of One' p. 3.

⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

¹⁰ Kirby *Guides for History Taking* p. 9.

¹¹ Case no 301 GB812 HB13/5/182/11 NHSGGCA.

Where information could not be elicited upon the patient's arrival, further details could be obtained through correspondence with relatives, friends and medical practitioners who were familiar with the patient's case. As will be explored in chapters six and seven, these letters were far less constrained by the structure of case note taking within Gartnavel, and, as the work of Coleborne has shown, correspondence written by family and friends reveal much as to public perceptions of abnormal mental behaviour and of the intimate relations that bound patients to those outside of the institution.¹² However, whether or not the anamnesis was generated through interview or through correspondence, the process of case note taking ultimately transformed these individual accounts into standardised groupings of evidence, collated under three distinct headings entitled 'Family History' 'Personal History' and 'The Onset of Present Illness'.¹³

Family history

Family History.

The maternal grandfather was an odd, rather strangely tempered man.

A maternal second cousin has been mentally affected. The father's side is negative.¹⁴

First, when looking to the construction of a patient's family history, initial enquiries made by Gartnavel's medical officers were often addressed towards 'the facts of hereditary in relation to mental illness'. Dating back to three generations, the immediate and collateral family lines were to be the subject of enquiry. Information about gross and minor mental disorders was obtained alongside descriptions of the 'general physique of the family', and therefore a picture of 'bodily, as well as the mental, morbidity' was to be obtained.¹⁵ Hereditary factors of causation played a noteworthy role within the case note record, with almost every case bearing a report of the patient's family history. Descriptions, such as the above, of the mental states of paternal aunts, the untimely deaths of siblings or the strange temperament of maternal grandfathers, were noted, alongside the presences of nervous diseases, of psychoses or suicides, of alcohol or drug addictions, of eccentricities, emotional instabilities, tuberculosis, syphilis, obesity or physical deformities, each alerted the interviewing medical officer as to the patients' potential predispositions. While a

¹² Coleborne 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880-1910' p. 427.

¹³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 70-72. See also Leys 'Types of One' p. 5.

¹⁴ Case no 398 GB812 HB13/5/183/54 NHSGGCA.

¹⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 70.

strong, healthy family history, free from physical or mental abnormalities was likewise noted down with precision.¹⁶

‘[C]linical experience’ writes Henderson, ‘forces the conclusion that heredity is of considerable importance’, with diagnostic categories such as ‘depression’ or ‘schizophrenia’ seen to evidence a high incidence of familial mental disorders.¹⁷ Yet, despite the evident significance of such enquiries, Henderson and Gillespie claimed that ‘Too much stress has been laid on the rôle of hereditary in mental disorders’ as this line of study was still little understood. Moreover, Henderson wrote that hereditary studies were based upon ‘clinical impression’ rather than ‘exact observation’ and statistical measurement. ‘Human families, with their long interval between generations, and the small numbers of their members’, were regarded as poor test subjects for studies in hereditary, which rendered a ‘paucity of satisfactory data’. Indeed, for those patients recognised as possessing a positive familial incidence of mental disorders, it was considered in many cases that ‘exogenous’ factors were necessitated to bring about underlying hereditary defects.¹⁸ The importance of studying both organic and environmental factors of causation was strongly highlighted in Henderson and Gillespie’s *Text-Book*, and as information given in the anamnesis informed later examinations of the patient, this dynamic perspective is reflected within Gartnavel’s case note records.

One such case that reveals the complex interplay, recognised by Gartnavel’s medical officers, between organic and ‘exogenous’ factors of causation, was the case of Hannah Matthews, a middle-aged, married woman, admitted to Gartnavel in 1929. In her case note records, Henderson wrote that for the past five weeks she had not slept well and that she had been ‘complaining of feelings of inadequacy’. Looking back to her family history, it was revealed that during her childhood years her father had been a ‘chronic alcoholic’, and that after her mother died when she was only eight years old she was removed to the care of a relative on account of her father’s drinking habits. As demonstrated in Kirby’s *Guide*, a history of alcoholism was considered a significant factor in the analysis of the family history, and for Henderson and Gillespie they concurrently wrote that certain mental disorders were ‘usually, if not exclusively, associated with alcohol’. Alcoholism was often

¹⁶ Kirby *Guides for History Taking* pp. 14-15.

¹⁷ In the 1920s in depth ‘hereditary studies’ were carried out on a number of Gartnavel’s patients, see ‘Hereditary Reports’ GB812 HB13/11/12 NHSGCA.

¹⁸ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 26-27, 69-70.

regarded as a ‘symptom’ of mental illness,¹⁹ but the extent to which it was productive of mental illness within subsequent generations was a highly debatable issue.²⁰ For Hannah, she later stated in interview with Henderson that it was ‘useless for her to strive to be any different, because “constitution cannot be changed”’. ‘She feels’, observed Henderson, ‘that because of her father’s habits and conduct she was bound because of her heredity to be affected by some incurable nervous illness’.²¹ This statement would have been significant to Henderson not only because it evidenced a familial incidence of alcoholism, but because it also revealed the patient’s ‘morbid’ reaction to this knowledge and the fatalistic outlook which sprung from her own understanding of hereditary disorder.²²

Personal history

Once an outline of the family history was obtained, questioning turned towards the patient’s personal history. From the ‘time of conception’ up until the ‘alleged onset of illness’, Gartnavel’s practitioners were to obtain a detailed account of the patient’s physical development, their ‘intellectual and social adaptation’, their sexual habits and interests, while they were also to ascertain whether there was ever any affliction of disease, infection or injury. The purpose of the personal history, wrote Henderson, was ‘to get a description of what the individual was at his/[her] or her best, what the response was to social, business and domestic life, and what were his ambitions, dreams and hobbies’.²³ As advised by Kirby, enquiries built up a chronological account of the individual’s development, with questions loosely directed towards the patient’s ‘Birth and Early Development’, ‘Intellectual and Social Development’, ‘Sexual Development and Function’ ‘Previous Attacks of Mental Disorder’ and ‘Etiologic Factors and Precipitating Causes of Present Psychosis’.²⁴

¹⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 39.

²⁰ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 42-44.

²¹ Case no 971 GB812 HB13/5/192/47 NHSGGCA.

²² Whilst discussing the aetiology of mental disorders in their *Text-Book* (1932) Henderson and Gillespie wrote that when it comes to organic factors of causation such as the effects of climate, of age, of trauma or of the little understood role of the endocrine glands, ‘it can hardly be doubted that the matter is very much more complicated than is supposed by many, who seem to expect a direct causal relationship between gland disease and mental symptoms... Not the glandular disease alone, but the whole personality has to be taken into account. For example, the patient’s reaction to the knowledge that he has a certain disease, *e.g.* diabetes, may itself be morbid. p. 66.

²³ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 74.

²⁴ Kirby *Guides for History Taking* p. 15.

Through a sampling of Gartnavel case note records, it becomes evident that, while informants ranged from patients' brothers and sisters to their parents or other close relatives and friends, Gartnavel's medical officers tailored their enquiries towards the particular relationship of the informant to the patient.²⁵ The parent of a patient, for instance, was sometimes asked about the conditions under which the patient was conceived, whether the pregnancy was 'welcome or unwelcome', and the difficulty of labour, while enquiry into the development of the patient at puberty, their love attachments, sexual habits and their long term medical history could sometimes be more easily directed towards a patient's friends or siblings.

In the case of one informant, who was the mother of an aristocratic young Irish patient, she related how the birth of her son had been without undue difficulty, that he developed normally but that he was afflicted with the 'habit of bedwetting, until even a year ago'.²⁶ By the time of his admission, he was 23 years old and she described him as 'impish, rather troublesome', although at school, and throughout his education at Eton, she considered that he did extremely well in his studies. He wanted to be a schoolmaster, she declared: 'it was the only thing he seemed to want'. She considered him not 'especially imaginative', no particular love affairs were known, and 'sex matters' were 'never supposed to have interested him'. His brothers and sisters, she related, 'always spoke of him as singular'; he 'constantly talked to himself' and occasionally burst into 'causeless laughter and singing'. She admitted, however, that she herself often went about 'talking to herself', and therefore had not paid much attention to 'such things'.²⁷

Another example relates to a young female patient, admitted in 1930, which was narrated by the patient's father and brother. The father recalled that the pregnancy and birth of the patient was considered quite ordinary and natural. She was a healthy child and developed normally, although the medical officer thought it 'worthy of note' that, when she was 5-6 years old, Zeppelin air raids were very common and 'the family used to hide e.g. under the table – to protect themselves from possibility of splintering glass'. Growing up she had 'no

²⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 70.

²⁶ In Henderson and Gillespie's *Text-Book* (1932) under the classification of nervous disorders in children it was stated that childhood behaviors such as 'Nail-biting, thumb-sucking, incontinence (nocturnal and diurnal) etc. were classified as 'Habit disorders'. Taking Freudian psychiatry into consideration, the development of habit formation within childhood was seen to influence greatly the development of 'temperament and character' in later life. 'Hence weaning and the education of the bladder, and especially the bowel function, become, on this theory, the critical points of development'. pp. 493, 504.

²⁷ Case no 398 GB812 HB13/5/183/45 NHSGGCA.

fits', 'no abnormal bed wetting',²⁸ but she was noted to have been afraid to sleep in the dark. At high school she was very well liked by everyone, 'took prizes', but worked herself too hard and was 'overconscientious'. A bit of a tomboy and a 'great sport', she could climb a tree 'like a monkey', and before the onset of her illness her father reflected that she 'wouldn't say or hear an unkind thing about anyone'.²⁹

Notwithstanding the evident significance of the informant's subjective viewpoint, clinical guides often warned that family informants provided partial, one-sided sources of information. One factor in particular, warned Henderson and Gillespie, may have stood out to the patient's family as the causative agent; an event, or an illness may have strongly been emphasised within their account, while it was 'often the one [factor] which has seemed of least importance to the family that has been chiefly responsible for the breakdown'.³⁰ With patients themselves sometimes asked to give an account of their personal history, these accounts could significantly differ from that given by friends or relatives.

Harriet Paterson, admitted to Gartnavel in November 1924, is for instance, portrayed by her father as a 'normal girl in every way'. Before her symptoms arose, her father recalls that she was affectionate to her family, 'modest and natural' in her mannerisms, 'played games, went to dances, was greatly interested in outside activities' and was a great favourite of many of her friends of the same 'and with the opposite sex'. However the account given by Miss Paterson seemed to 'differ materially ... from that given by her father'. Miss Paterson, writes the medical officer, 'had many friends and from her own and her father's accounts she was evidently a great favourite' but 'her own account of her personality differs materially however from that given by her father'. In her own account, Miss Paterson states that she had always been nervous, emotionally unstable, and 'extremely sensitive to other people's opinions'. Contrary to her father's testimony that she had always been most affectionate towards her family, Miss Paterson related to the medical officer that she had always 'come into conflict with her mother' and that she positively

²⁸ For Charles Macfie Campbell, his studies upon child psychology advised that such 'undesirable traits' as 'bed-wetting', 'masturbation' and 'bad-dreams' evidenced neurotic instability in the child. See Campbell 'The Role of the Psychiatric Dispensary' p. 452.

²⁹ Case no 790 GB812 HB13/5/189/34 NHSGGCA.

³⁰ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 72.

‘hated’ one of her sisters. All her life, the medical officer recorded, she had ‘suppressed these feelings’ and had never enjoyed a happy home life.³¹

In alignment with Meyer, the ‘first anamnesis’ was therefore termed a ‘layman’s document’. Evidence provided by family informants was to be ‘reviewed’ and judged ‘in the light of the facts obtained during the observation of the patient’ and, in certain cases, ‘by supplementary enquiries’.³² Information provided by patients themselves could contradict, corroborate or supplement that provided by relatives and medical staff, and therefore the anamnesis was a fluid and unstable document that could undergo further revision throughout the course of a patient’s treatment. Such instability was one of the primary reasons for Meyer delaying the diagnosis of a patient until many months had past, until all the ‘facts’ of the case were drawn together and analysed as a dynamic whole.³³ The degree of caution and uncertainty shown by Meyer is, as I suggest in the following chapter, upheld by Henderson, with medical officers guided to ‘sort out the facts’ of the individual case, rather than place patients in distinct diagnostic groupings.

Moreover, as the anamnesis progressed from an analysis of the patient’s personal history, to an account of the onset of illness, Henderson and Gillespie’s suggestions are again in alignment with Meyer, as they advise that medical officers do well to remember the inherent subjectivity of the informant. ‘It is notoriously difficult’, agreed Henderson and Gillespie, ‘to get a reliable statement of the family history. The relatives often feel sensitive about their position [and] they are apt to think that the patient may resent information being given’.³⁴ It was advised that the medical officer thereby guide the informant ‘step by step’ as they described the onset of the patient’s symptoms. General statements offered by informants were considered of little or no value; rather, Henderson and Gillespie wrote that ‘we must get an exact description of what the patient’s conduct has been, and how he has reacted to his difficulties’.³⁵

³¹ Case no 268 GB812 HB13/5/181/36 NHSGGCA.

³² Meyer ‘Outlines of Examinations’ p. 231.

³³ Meyer ‘An Attempt at Analysis of the Neurotic Constitution’ (1903) p. 91.

³⁴ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 68.

³⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 72.

'History of present illness'

During the Summer the patient was in a poor state of physical health. ... One evening about two months ago she became rather excited and emotional and expressed strange ideas to her sister. She talked quickly and excitedly and said she had received a message telling her that she was to be a second Virgin and that she was to go to Lourdes by aeroplane. Her sister reasoned with her ... and she resented her sister's unbelief in her strange statements. Her slightly excited state lasted for about [redacted] and then it appeared to pass off. A month ago it was seen that she had persecutory ideas. Her aunt to whom she had always been very friendly disposed came to visit her but the patient refused her admittance to the house ... Some days ago she said that a message had been sent to her telling her to go to Rome ... The informant stated that she thought her sister had auditory hallucinations but she cannot give any evidence of visions. ... She has not been sleeping well and her appetite has been poor.³⁶

Within this final section of the anamnesis, Gartnavel's practitioners endeavoured to pinpoint 'as accurately as possible' the date when the patient was first noticed to deviate from their normal state of behaviour. By gauging whether the onset of illness was 'insidious and gradual, or sudden', Gartnavel's psychiatrists began to weigh up the significance of 'endogenous' and 'exogenous' factors of causation. In addition, Henderson and Gillespie stated that the examining medical officer should be 'quite clear whether there have been suicidal or homicidal tendencies', and whether there was 'impairment of physical health' such as 'sleeplessness, disordered appetite, a loss of weight and constipation or diarrhoea'.³⁷ As evidenced in the above case note record, observations of the 'normal' state of a patient's personality directed Gartnavel's psychiatrists towards the importance of specific chronological events that altered their characteristic patterns of behaviour. Possible psychological as well as constitutional factors are taken into account, and as the poor physical health of this patient several months before the onset of her mental illness was highlighted, the colouring of her 'delusions' pointed to environmental influences originating from newspapers, religious texts and her involvement with the church.

For Henderson and Gillespie, it was therefore not enough to 'simply have the statement "He is delusional", or "hallucinated" etc'. Rather, they advised readers to establish 'what the attitude has been towards [a patient's] intimate relatives and friends, whether there has

³⁶ Case no 330 GB812 HB13/5/182/40 NHSGGCA.

³⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 71-72.

been a change in his mood, and whether peculiar ideas, delusions, suspicions or unusual interests have been spoken about and cultivated'. It was considered of great value 'to get an exact description of the delusions and hallucinations [if any were present], and how the patient has reacted to them'. Therefore, this part of the anamnesis often offers the most densely laden descriptions of the patient's thoughts, behaviours, mannerisms, emotions and physical state from the onset of their observable symptoms to the date of admission.³⁸ Moreover, as Henderson and Gillespie wrote that such descriptions were only of value once the medical officer obtained a detailed portrayal of the 'setting in which the symptoms have occurred', descriptions abound of the domestic, work and social settings in which individual cases emerged.

In a joint publication authored by Meyer and Kirby in 1908, they established that at this point in the anamnesis it became 'essential' that the practitioner 'siz[e]-up ... the situation and circumstances to which the patient is expected to adapt himself or which he fails to meet'. In cases where a clear organic factor of causation was present, such as 'toxic infectious disorders' and 'direct affection of the brain', the wider environmental backdrop was supposed to 'matter little ... except inasmuch as it brings with it the toxic or infectious, or other factors'. But where the disorder evidenced a 'psychogenic'³⁹ reaction type; wider social, domestic, and work environments were of far greater interest.⁴⁰ 'The commonest mental factors', wrote Henderson and Gillespie, that contribute towards the psychological components of mental disorders occur in 'business worries, domestic difficulties, dissatisfactions of all kinds, disappointments and worries in the sexual sphere, and deaths of relatives'. Indeed:

It is such situations as these that the individual, especially the susceptible individual, finds it difficult to face. He may surmount one difficulty successfully, only to go down before an accumulation of troubles. It is not the situation itself that matters, but what the subject feels about it.⁴¹

³⁸ Ibid p. 72.

³⁹ The meaning of psychogenic is distinguished by Meyer from psychological as Meyer speaks of anatomical changes brought about by mental, i.e. psychological factors such as stress, frustration etc. For studies which focus upon this distinction see J. E. De Vylder 'The Fall and Rise of Adolf Meyer's Psychogenic Etiology of Dementia Praecox (Schizophrenia): 1903-1910 and Beyond' *Smith College Studies in Social Work* 83, 1 (2013) 2-17.

⁴⁰ Adolf Meyer and George Hughes Kirby 'Notes of Clinics in Psychopathology' privately printed in 1908, reprinted in *The Collected Papers of Adolf Meyer Volume III Medical Teaching* ed. Eunice Winters (Baltimore: The Johns Hopkins University Press, 1951) p. 139.

⁴¹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 59.

With patients' reactions to such everyday situations being brought to the fore of investigation, anamneses highlight some of the culturally contingent factors considered significant to the aetiology of mental disorders. Also illuminated is the wider diaspora of Gartnavel's patients and the journeys they made before their admission. By presenting the following cases in which both exogenous and endogenous factors of causation were identified, Gartnavel's case note records reveal a geographical matrix of social, domestic, work and other environments against which patient histories were set. It is from this matrix that we learn of the tangible settings considered most significant to the individual case.

Environmental and organic factors of causation

When first looking to the environments that framed cases considered as organic reaction-types, an array of social and geographical settings such as ships' cabins, police cells, train stations and military hospitals emerge from the anamnesis. In such cases, the most numerous of which stemmed from syphilitic infection, senile dementias, alcoholism, drug addictions and infective exhaustive cases (primarily caused by malarial infection, influenza smallpox etc.) the primary site of investigation was the body, but the peripheral environments in which their symptoms were displayed played a significant, if secondary role in mapping the aetiology, diagnosis and prognosis of the case.⁴²

In the anamnesis of Richard Govan who was admitted in October 1927 and later diagnosed with G.P.I. (general paralysis of the insane), a statement given by the patient's brother relates how Govan had, very much out of the blue, been found in Crewe Railway Station around 4am. Seen to be 'addressing the bystanders in such a way as to bring him to the notice of the officials', he was taken to a police office, from which he was transferred to a local mental hospital. '[R]ambling in speech' and showing himself quite content with the surroundings of the mental hospital, this environment, the informant recalled, 'would not have pleased him normally'.⁴³ A second G.P.I. patient, Walter Parson, was admitted in August 1923 and was described by the informant (his friend) as having acted in a 'peculiar' manner during the last five years. Employed by a firm of Chartered Accountants in the South American city of Rio, Parson was seen to have made 'an excellent reputation for himself as an accountant', but in 1914 he contracted syphilis, and despite receiving treatment by 1918, his friends began to notice significant changes in his mental state.

⁴² Ibid p. 273-362.

⁴³ Case notes no 595 GB812 HB13/5/186/70 NHSGGCA.

Passing back and forth between periods of relative normality and ones where he acted with extravagance, was forgetful and paid little attention to his personal appearance. After receiving hospital treatment, his friend accompanied him on the voyage back to Scotland, and on board, his friend noted that Parson acted in a ‘very pleasant and almost childish’ manner. He expressed delusional ideas that his brother had sent him a cheque for a large sum of money, and told some ‘fantastic stories about elephant hunts’ and ‘things that had never happened’. It was noticeable to his friend that Parson could never find his cabin.⁴⁴

The railway station, the police station, the company office, the ships cabin: such tangible settings brought into stark relief the behaviours of an individual in the chronic phase of G.P.I.⁴⁵ Because the origins of organic reaction-types such as G.P.I. could be traced with a moderately high degree of accuracy to specific infectious agents through laboratory testing and physical examinations, the environment in which their symptoms played out was not primarily aetiological importance; rather, it contextualised the behaviours and reactions which were symptomatic of such degenerative disorders. Investing case note records with such rich descriptive detail allowed Henderson’s application of dynamic psychiatry to extend past the analysis of disease within laboratory and morgue settings, and to seep into the ‘concrete problems’ faced by patients, as disease and infection shaped their ‘journey through life’.⁴⁶

G.P.I. is one of the rare examples where a single site of infection was identified. For the majority of disorders, no one clear cause could be discerned. ‘A mental disorder’, explained Henderson and Gillespie, ‘is the sum of many conditions, and the end-result a long chain of processes’.⁴⁷ The environments in which such cases occurred were considered both a backdrop for, and a constituent component of, a dynamic reaction. In the case of Margaret Gray, for example, admitted in March 1925 at the age of 20, the informant’s description of the onset of illness was framed against a domestic backdrop, while close attention was paid to the changing familial relations that had occurred within the month before her admission. Her father recalled that one day, when he was having his

⁴⁴ Case no 292 GB812 HB13/5/182/2 NHSGGCA.

⁴⁵ The difference between acute and chronic states of organic reaction types were commonly differentiated, with acute organic reactions resulting from a ‘temporary toxic process affecting the brain’ i.e. in cases of acute alcoholism, whilst chronic organic reaction-types denoted ‘more severe tissue change’ which was often irreversible and which showed itself in the ‘progressive degeneration’ of a patient’s intellect, emotions and personality. See Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 273.

⁴⁶ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 188.

⁴⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 26.

mid-day meal, his daughter was standing nearby when she ‘complained to her sister that she was feeling faint and asked for a drink of water’. While her sister was fetching the water, she ‘collapsed’, her face becoming ‘washed’ and her body ‘quite rigid’. The ‘description’ noted one of Gartnavel’s medical officers ‘appears to have been an epileptic fit’. After she recovered, her father recalled, she developed ideas which the medical officer considered of a ‘grandiose character’. She spoke of her family, saying they were ‘going to live in a hotel and that her father will not need to work’. On another occasion she set the dining table for many people, declaring that ‘they were going to entertain many guests’. She was observed to have developed a ‘peculiar precise mode of speech’, and at times she seen to become ‘emotional and tearful’. One time while in this state, she ‘declared that her father was being cut into bits’; she sat and stared into his eyes for minutes on end, commanding him to sit in certain postures. At other times she was playful, knocking on the front door and pretending someone had knocked from the other side.

This case, I argue, demonstrates how the portrayal of an organic reaction was tightly bound to the familial relations and domestic settings that contextualise the progression of symptom picture. A significant factor in this case was that the aetiology of the patient’s apparent epileptic fit - a disorder little understood during this period - was unclear, and therefore both organic and environmental factors of causation may have been taken into account. Organic forms of epilepsy were traced in a number of cases to head traumas, to chronic disease of the heart etc. but for cases such as Miss Gray, designated as a form of ‘essential epilepsy’, ‘no tangible cause’ had so far been discovered that could account for the proceeding mental symptoms.⁴⁸

Another case, which shows the complex, often indistinct boundaries between the psychological and organic aetiology of mental illness is seen in the case of Andrew Weir, a medical doctor admitted to Gartnavel in August 1925. The anamnesis, which was given by his wife, informed the medical officer that Weir’s condition began when his heart started to trouble him in 1922. Her husband, she stated, had worked out in the Straits Settlements of Southeast Asia and while there, had been advised to return to Britain by another doctor. However, anxious to stay in his position until he qualified for a pension, her husband ‘would not follow the doctor’s advice’. In 1925, during the monsoon season, his wife reported he ‘took a chill’ which turned into bronchitis, and from this point on it became

⁴⁸ Case no 483 GB812 HB13/5/185/18 NHSGGCA. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 363.

clear his memory was starting to fail him; so much so that he was forced to give up his work, after which 'he became very depressed'. His memory, his wife informed the medical officer, further deteriorated. He could no longer remember his father was dead, and 'he had forgotten most of his past life'. Gartnavel's medical officers concluded that the case was a 'very difficult one'. Probable aetiological factors included the possibility of some 'tropical condition', and therefore the climate, together with a host of tropical infectious agents, were of significance to the symptomatic picture of organic disturbance.⁴⁹ But, as Henderson and Gillespie reckoned the 'difficulty of adaptation to a foreign country and to a society with unfamiliar customs' could cause psychological disturbances, the cultural, as well as the climatic environment, was implicated in the aetiology of his disorder.⁵⁰

Environment and psychological factors of causation

For those cases in which psychological factors were understood to play the prominent role in the aetiology of mental disorder, two environments appear in the greatest proportion amongst case note records. The first that appears within the anamnesis with regular occurrence is that of the work environment, as patients' reactions within places of occupation (which were often public) were compared with their reactions within private spheres such as the domestic household. When considering the work environment, Gartnavel's *Annual Reports* reveal a patient population in possession of an assortment of occupational histories, ranging from that of 'Grocer', 'Hotel Keeper', 'Ironmonger' and 'Labourer', to 'Miner', 'Teacher', 'Doctor' 'Tailor', 'Typist', 'Clerkess' and 'Housewife'.⁵¹ For some family members, patients' symptoms were seen to stem directly from pressures or difficulties faced in their place of work, while for others the work place merely functioned as a backdrop against which to highlight abnormalities of behaviour. Viewed by their colleagues on a daily basis, changes in their behaviour, intellectual abilities, or interactions with others were often noticed, and the following case note records demonstrate how these settings became interwoven within informants' narratives; becoming part of the 'exogenous' factors of causation considered within the anamnesis.

⁴⁹ Case notes no 484 GB812 HB13/5/185/19 NHSGGCA.

⁵⁰ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 63.

⁵¹ 'Table 12. Showing the Occupation or Social Position in the Admissions During the Year 1922' *The One Hundred and Ninth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) For the Year 1922* (Glasgow: Gartnavel Royal Mental Hospital, 1923) p. 42.

In an anamnesis given by the wife of Percy Williams, a middle-aged male patient, she stated her husband's symptoms first became apparent to her in 1918 when he had a 'nervous breakdown'. The patient, who was a mine inspector, developed a 'morbid fear of going down in the cages'. After having plucked up the courage to go down in the cage and into the mine, this fear wore off and he could once again concentrate on his work, but above the mine his wife related how 'the thought of going down preyed on his mind'.⁵² For another patient named Peter Richards the General Strike of 1926 was aligned with the onset of his 'depressive' symptoms with a lack, rather than a fear, of work aggravating his symptoms. Having worked as a miner for 21 years, and then as a 'traveller in drapery' for the next 20, he was suspended from his work due to the nationwide strike. The informant related how the patient could find no other work and that 'he gradually began to get depressed'. The depression was noted to have 'deepened steadily' during his time of unemployment and, although his wife found him a few hours work a week down a 'small pit', it seemingly did nothing to "lift" his depression'.⁵³

As well as working conditions and varying states of unemployment and inactivity recognised by the lay public as 'exogenous' factors of causation, the fear of dismissal and financial hardship was likewise recognised as a significant contributory factor. Archibald Adams, admitted in 1923, was employed as a butler to one of the great textile manufacturing families of Paisley. His wife described him as having always been 'very nervous', but that his worries did not escalate into mental disorder until three months previous to his admission when he began to worry about his position. His 'master' was cutting down on the number of outside staff employed within his house, and the patient worried that he too would lose his situation. Despite assurances by his employer that his job was secure, he continued to fret. He was heard to say he had not kept the wine books up to date and 'refused to be reassured when the master told him that that was no cause for worry'. After a 'very busy day' when the house was entertaining guests, he spoke to his wife, stating he 'felt useless', and thereafter 'shunned all company'. This, his wife considered, was quite unlike his former outlook and general behaviour.⁵⁴

In 1921, Henderson wrote in his first 'Report of the Physician-Superintendent' that over the post-War years the resulting economic and social strain, combined with high living

⁵² Case no 234 GB812 HB13/5/181/2 NHSGGCA.

⁵³ Case no 473 GB812 HB13/5/185/8 NHSGGCA.

⁵⁴ Case no 294 GB812 HB13/5/182/4 NHSGGCA.

costs, was perpetuating the spread of mental disorders within certain sectors of society. Women in particular were seen to suffer disproportionately from adverse economic and social conditions, as the number of female admissions was outstripping males throughout the 1920s.⁵⁵ For one father who wrote to Henderson in 1926, economic strain and difficult working conditions were strongly accentuated as precipitating factors in his daughter's case. Catherine Lockhart, who had sailed to Canada 'with the object of improving her position', was sent home several months later in that which her father described as a 'very miserable, depressed state'. Before her departure her father states that she 'appeared to be as she had appeared to be during her whole life', healthy both mentally and physically, but that she worried due to her mother's ill-health and her father's unemployment. Upon her arrival at Winnipeg, she entered into domestic service, and this, her father stressed, became a great worry to her, because beyond her own household she had had no previous experience of this kind of work. After a month she obtained a stenographer's position at the Winnipeg Piano Co., and she told her father how she had to 'work very hard and continuously to overtake the work given her each day'. Three weeks or so later she began to suffer from pains in her temples, and wrote to her father that she feared her 'mind was becoming affected'. After six more weeks she felt compelled to leave her position and while attending a church service she attracted the attention of a 'lady', who took her to the Winnipeg General Hospital. After spending two days in the Psychopathic Department, a 'Government Lady Official' for Montreal arranged for her transportation back to Scotland, and from here she was put aboard a steamer under the charge of the ship's stewardesses who cared for her during the journey home. Upon reaching home, her father recalled that she talked and muttered incessantly, 'fretting about having gone to Canada', saying "Why did I go away?" "Why did I leave you, mother, so ill and father idle?" "Why did I leave my good job?" and sometimes "Why did I leave Canada?" "Why did I not fight it out there?".⁵⁶ With her thoughts, ambitions and regrets torn between two oppositional geographical, cultural and work environments, the anamnesis laid the foundations for further enquiries directed towards the patient, in which her reactions to foreign places and domestic spaces were further elucidated.

With cases such as this intimating towards the causative role of domestic, financial and work related worries, the environment of the family household also often furnishes informants' reports. With important factors of causation recognised by Henderson and

⁵⁵ Henderson 'Report of the Physician-Superintendent for the Year 1921' p. 14.

⁵⁶ Case no 463 GB812 HB13/5/184/60 NHSGGCA.

Gillespie to stem from ‘a family or environmental nature’, it was considered ‘essential’ that the anamnesis include studies of the ‘social conditions’ and ‘family life’ of the patient.⁵⁷ In the case of Robert Donaldson, a young man admitted in 1923, his mother related how her son had worked well as a salesman for several years in the Cooperative, but that at the onset of his illness, he returned home complaining of tiredness and of needing to lie down. Six weeks previous to his admission he had given up work, feeling that he was unable to carry on, and yet he was not sleeping well. He reportedly stated to his mother that he had ‘something wrong inwardly’. He had ‘very intricate theories about his body’ which he likened to an ‘engine which had elaborate rotary movements etc’. She then related how her son had developed a quick temper, and recalled that when strangers had come into the house he had ‘got up without a word’ and went into another room.⁵⁸ By encouraging the informant to juxtapose her observations of her son’s inner feelings and thoughts with his externally projected behaviours, a dynamic symptom picture was gradually assembled of the patient’s ‘faulty’ modes of adaptation to his physical (bodily) and social environments.⁵⁹

Moreover, while anamneses built up a wider picture of patients’ domestic relations and household environments, the following record also reveals somewhat of the active roles, played by friends, family members, lovers and medical practitioners, in shaping a patient’s experience of mental illness. The father of Harriet Paterson, when reflecting upon the onset of his daughter’s illness, stated that when his daughter returned home in the winter of 1921 from her first term studying at St Andrews University, he noticed her to be anxious, emotional and ‘expressed ideas of unworthiness’. After Christmas, he father relates how his daughter stayed at home due to her ‘mental condition’, but by June 1922 she met a young man to whom a week later she became engaged. From this point on in the father’s narrative, his disapproval of his daughter’s conduct towards men was a strong and often repeated theme, and the case record evidences how contemporary notions of sexual impropriety shape his description of his daughter’s behaviour.

⁵⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

⁵⁸ Case no 142 GB812/ HB13/5/179/42 NHSGGCA.

⁵⁹ When converting such observations into a symptom picture Henderson and Gillespie wrote that ‘Failure of adaptation at any level of development implies dissatisfaction’. Taking the above stated symptoms into account, ‘irritability’, for example, was defined as a symptom of a ‘lack of harmony of the subject and his environment’, whilst the patient’s description of his body as a machine pointed towards ‘Ideas and feelings of passivity and influence’. Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 88, 94.

Miss Paterson's whirlwind engagement, for instance, was contrary to the wishes of both sets of parents and considered not in-keeping with her 'natural' temperament. Seen by her father to become antagonistic towards her parents, while going 'about constantly with the boy', this, states her father, went on for about a year until a family doctor advised she undergo the famed Weir Mitchell rest treatment.⁶⁰ Separating his daughter from her fiancé she spent several months in a private ward of a hospital in Birmingham. Medical correspondence reveals that it was here that a young doctor suggested Miss Paterson was suffering from a morbid fear of tuberculosis, an illness she had suffered from as a child, but as Miss Paterson's father continues to detail his daughter's personal history, themes of sexual impropriety and family disharmony, rather than of tuberculosis and fear, surface as the integral part of his narrative.

After several months in the hospital she was discharged but her behaviour was noted as being 'unrestrained and irresponsible' as she quarrelled with her sisters and acted in a 'bold way towards men'. After several 'violent scene[s]' a family doctor 'ordered the patient to a nursing home', after which she was certified and admitted to a nearby asylum. A month later, her father reported that his daughter was much more to her normal self, as she was affectionate towards her parents and showed little outward sign of 'mental excitement'. By November 1923 Miss Paterson was discharged and allowed to see her suitor once a week, but after some months it became evident that the young man 'wished to break off with the patient'. Once again she became 'unmanageable' and 'wildly extravagant'. Her father took her on a trip to Harrogate and there, he observed, she had behaved in an 'unseemly way towards a young man who was there'. She was persuaded by her father to admit herself into a private nursing home in Glasgow, but, after the staff found it 'impossible to control her', she was certified and admitted to Gartnavel.⁶¹

With informants describing the inharmonious relations that existed between patients and their social and familial surroundings, the anamnesis enabled Gartnavel's practitioners to identify patients' 'faulty' adaptations within concrete settings. Yet, while Henderson adhered to Meyerian principles, the anamnesis played a complex, somewhat dualistic role.

⁶⁰ Weir Mitchell (1829-1914), a Philadelphian physician, proscribed a treatment of isolation, rest, feeding, electrotherapy and massage to treat 'nervous women'. The patient was instructed to lie in bed, sometimes for 24 hours a day, and a special nurse would sleep in the same room, reading and attending to her. Visits from friends and relatives were often forbidden. Diana Martin 'The Rest Cure Revisited' *The American Journal of Psychiatry* May 1 164 (2007) 737-738 p. 737.

⁶¹ Case notes no 268 GB812 HB13/5/181/36 NHSGGCA.

For Meyer, the underlying principle of psychobiology was that we are all ‘social beings and members of a family and a community’, and therefore one must act in alignment with the ‘common sense consensus’ that dictate the beliefs and standards of society.⁶² The role of the psychiatrist was consequentially to teach individuals to live harmoniously within society and to conform to the common consensus, but Meyer also stated that ‘Progress in the mental health issue, calls for a great deal of the right balance between individualism and civic solidarity’:

If we want to teach some people how to live, we all must realize that we have to give a chance to each according to his or her aptitude the right to be honourably that which one is forced to be through the laws of nature and endowment, and the right to be stronger as a part of a well-fitted and truly amalgamated social body.⁶³

‘For one reason or another’, concurred Henderson, be it ‘psychic, social, toxic, organic’, patients who suffered from a mental disorder were seen to have ‘been unable to hold their own; they have failed in their adaptations; they have become for the time being social failures’. Once information garnered from the anamnesis attested to a patient’s maladjustment to the concrete demands of the environment, Henderson supposed that ‘with rest, watchful care, good nourishment, drugs’ and the application of more dynamic methods such as occupational therapy, dreams analysis and talking cures, ‘an adequate compensation may sooner or later be built up’.⁶⁴ Yet ‘the problem of mental disease’ itself, wrote Henderson and Gillespie, ‘has never been adequately tackled’. Following on from the work of Meyer, Campbell and others within North America on the promotion of mental hygiene, Henderson wrote in his *Annual Report* for 1921 and 1922 that notwithstanding the certain reforms such as the re-opening of the out-patient psychiatric clinic, the ‘the problem of prevention, until recently’, had been confronted ‘almost not at all’.⁶⁵

⁶² Meyer ‘Organization of the Works of the Henry Phipps Psychiatric Clinic’ p. 208.

⁶³ Adolf Meyer ‘The Purpose of the Psychiatric Clinic’ p. 87.

⁶⁴ Henderson ‘Occupational Therapy’ p. 64.

⁶⁵ From the early 1920s onwards Henderson’s involvement with the Scottish Association for Mental Welfare, (made up of ‘educationalists’, ‘sociologists’, ‘psychiatrists’, ‘lawyers’, churchmen and others’) saw him follow in the footsteps of Meyer and Charles Macfie Campbell, who aimed to establish wider principles of mental hygiene within the community. Henderson speaks of his involvement with the Scottish Association of Mental Welfare in a letter to Meyer, see Individual Correspondence Henderson, Dated 1st December 1931, Box no I/1659/14, AMC. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 25.

Throughout Henderson's career, this dualistic principle, which explored both endogenous and exogenous factors of causation, structured his approach to case note taking.⁶⁶ Moreover, this stance stimulated Henderson to extend his sphere of influence beyond Gartnavel's walls and into the public domain, and as demonstrated in following chapters, the principles of mental hygiene ran deep throughout Henderson's career. By advocating that psychiatrists study the root causations of mental disorders, be they environmental, constitutional, or a mixture of both, Henderson endeavoured to extend psychiatric knowledge and therapeutic activities from the mental hospital into community life. By teaching patients and nurses the 'principles of mental hygiene', and by educating the public to look upon mental illness as an '*illness*' and not a 'disgrace', dynamic psychiatry was in many ways endeavouring to change, not only patient's adaptations to the environment, but the wider social environments from which mental illnesses were consequently envisaged to stem.⁶⁷

Personality

Personality. He has always been bright and enjoyed the company of others. He is a great reader + at one time had a very retentive memory. His hobbies have been collecting old books + pictures but he has never gone in for athletics, although he was a great walker at one time. He has always been rather an agnostic although as a boy his religious training was fairly strict. He has always been a frank, outspoken man as far as his brother knows ... The brother knows very little of his more intimate life. He has never married and has never had any special attachment to any women. He has always been very moderate – a bottle of wine at dinner but never any to excess.⁶⁸

'Every individual', Henderson quoted Meyer as having stated, 'is capable of reacting to a very great variety of situations by a limited number of reaction types',⁶⁹ and therefore, as the anamnesis shed light upon the patient's social and physical environments, it simultaneously revealed the 'typological' patterns of adaptation and maladaptation that characterised the 'personality' of the individual.⁷⁰ As touched upon in chapter two, the

⁶⁶ Henderson 'Report of the Physician-Superintendent for the Year 1921' p. 19.

⁶⁷ Ibid pp. 18-19. See also 'Report of the Physician-Superintendent for the Year 1922' p. 21.

⁶⁸ Case notes no 595 GB812 HB13/5/186/70 NHSGGCA.

⁶⁹ Henderson 'Introduction' *The Collected Papers of Adolf Meyer Volume II* p. xii.

⁷⁰ The concept of personality was, in this period, an evolving concept that was being transformed within wider artistic, literary, architectural, etc. movements that infused psychobiological and psychoanalytic studies of the 'self'. I will go into greater detail further into this chapter upon the meaning of personality within dynamic psychiatry. For an overview of the growing cultural consciousness in North America that

concept of personality had steadily grown in nineteenth and early-twentieth century psychiatry. An accumulation of studies which emanated from the works of the Parisian neurologists Jean-Martin Charcot and his critics Hippolyte Bernheim and Pierre Janet,⁷¹ paved the way for studies of ‘multiple personalities’ and later, through the work of Meyer, Hoch and George S. Amsden, of ‘constitution’ and ‘personality types’.⁷² From the mid-1920s onwards, a separate section entitled ‘Personality’ was increasingly incorporated into Gartnavel’s case note records. Often this section followed on from the ‘History of Present Illness’, and this insertion reflects the growing importance of psychology to the study of psychiatry during this period.⁷³

As emphasised by Meyer and Amsden, the personality was not to be viewed as a fixed, static attribute of an individual, but rather it was recognised as stemming from a ‘continuous stream of developing traits and characteristics’ that adjusted to the demands of an individual’s environment. For those who continuously adapted their sense of self to fit harmoniously with their surroundings, this was understood by Meyer as the foundation of a healthy ‘personality integration’.⁷⁴ Yet it was also recognised that for some individuals, their characteristic modes of adaptation were shaped by ‘deeply-seated or persistent tendencies’ that made for bad reaction types. ‘Deficiencies’ stemming from hereditary, constitutional, physical or environmental origins were understood to lessen an individual’s ability to adapt successfully to ‘reality’.⁷⁵ The schizoid, paranoid and cyclothymic personality-type, were each considered to display repeatedly unhealthy ‘mental reactions’ to the demands of their environment.⁷⁶

For Henderson, to understand the formation of such ‘unhealthy’ reactions, studies of personality were intended to reveal whether patients were ‘loaded in various ways – by

was redefining the concept of personality see Lamb *Pathologist of the Mind* pp. 10-11. See also Leys ‘Types of One’.

⁷¹ Gach ‘Biological Psychiatry in the Nineteenth and Twentieth Centuries’ pp. 384, 390.

⁷² Adolf Meyer ‘Untitled Working Notes on Psychopathic Personality’ XII/1/59 Baltimore: Meyer, AMC. This document was written some time after 1913 when Meyer began working at the Phipps Psychiatric Clinic.

⁷³ Adolf Meyer ‘The Value of Psychology in Psychiatry’ originally read in a symposium on ‘The Relations of Psychology and Medical Education’ in Washington D.C. December 1911, reprinted in *The Journal of American Medical Association* LVIII (1912).

⁷⁴ Adolf Meyer ‘Psychobiological Personality-Organization’ p. 277.

⁷⁵ Kirby *Guides for History Taking* pp. 21-22.

⁷⁶ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 383. The cyclothymic personality type is now recognised as a disorder akin to, but less severe than, bipolar disorder.

inheritance, by physical defects ... endocrine disorder ... intellectual deficiency'.⁷⁷ 'The more intimate part of the environment constituted by the body', wrote Henderson and Gillespie, was also considered important to the formation of personality, as 'mental representations of bodily activities are regarded as part of the self'.⁷⁸ But it was only when these individuals, 'whether handicapped or not', had to face the 'concrete problems in his journey through life' that 'faulty habits of reaction' such as 'shyness, sensitiveness, plastic obedience to others',⁷⁹ 'feelings of inferiority' or, conversely, an 'egotistical, vain, proud mentality'⁸⁰ were all recognised to produce unhealthy personality types.⁸¹

With the aid of Hoch and Amsden's 1913 published guide to the examination of 'personality types', personality studies became one of the cornerstones of dynamic psychiatry, and in 1932 Henderson and Gillespie fully incorporated Hoch and Amsden's studies of the personality into the *Text-Book* under 'Method of Examination'.⁸² To enable medical practitioners to explore systematically the formation of personality, the following guide was devised which comprised of eight main headings:

- General intelligence, knowledge and judgement.
- Output of energy.
- General attitude towards environment.
- Attitude towards self : inner mental life.
- Attitude towards reality.
- Mood: emotional reactions.
- Sex instincts.
- Feeling of inferiority.⁸³

This guide was condensed by Amsden in 1923 to just four investigative groupings which directed enquiry to the development of the 'Intellectual faculties', the 'Somatic demands' (physical activities), 'The individual's self-criticism and self-estimate' and 'The urgency or imperative to adaptation'.⁸⁴ Gartnavel's case note records, however, evidence the continued use of the original eight main headings into the latter years of the 1920s, so it is

⁷⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 188.

⁷⁸ *Ibid* p. 112.

⁷⁹ *Ibid* (1932) p. 190.

⁸⁰ Kirby *Guides for History Taking* p. 24.

⁸¹ See the chapter on 'General Psychopathology' in Henderson and Gillespie *A Text-Book of Psychiatry* (1932) see also pp. 104, 112, 188.

⁸² Millon *Disorders of Personality* p. 665.

⁸³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 72.

⁸⁴ *Ibid* p. 73.

likely that Gartnavel's medical officers were not wholly attuned to the latest developments across the Atlantic.

In many of the earlier case note records, enquiries into the personality were integrated into the 'Personal History'. But as the decade went by, research into the personality began to take on a more distinct character, with separate sections reserved for the collation of information surrounding character, sociability, hobbies, and moral and sexual practices. By the end of the decade, the style and format of the 'Personality' notes underwent further modifications, as demonstrated in the following personality study of one patient, Marjorie Fullerton, produced in 1928, that was closely akin to the earlier structure advocated by Hoch and Amsden:

Personality. She seems to have been a normal girl but the informant is 7 years her junior. She was a good mixer as a young girl with both boys + girls + she had, + still has, a lot of friends.

Output of energy was high + continuous. She was a good teacher. Got on well with colleagues + was offered advancement several times.

Moral Standards Inclined to be prudish not over religious but not given to any laxness of any kind

Mood She was not optimistic but inclined to be anxious + to worry over trifles.

Attitude to Self. She was at heart conceited and inclined to put others right, tell them what to do.

Attitude to Others In spite of her conceit she also had a feeling of inferiority especially towards her colleagues, she was not a leader and she was inclined to say that others were better + happier than she

Self Assertion was not present She did not push herself and several times refused advancement when she was offered.

Adaptability She is not adaptable + even after a number of years she was never shaken down as a housewife⁸⁵

With records produced in the late 1920s paring away the narrative stylistics that characterise earlier anamnesis, the condensation of personality studies to key, succinct statements may reflect a more proficient use of Hoch and Amsden's guide. With a closer filiality shown by the above 'Personality' study to the working sentiments established by Hoch, Amsden and Meyer, this may suggest a strengthening of professional relations

⁸⁵ Case no. 655 GB812 HB13/5/187/55 NHSGGCA.

between Gartnaveil and the North American institutions which harboured the principles of psychobiology.⁸⁶

Collating the anamnesis

With Henderson's application of dynamic psychiatry looking to the complex interrelation between exogenous and endogenous factors of causation, which included studies of heredity, constitution, personality, disease and injury, Henderson and Gillespie wrote that at this point in the examination it may become apparent that 'the cause [of mental illness] is neither physical nor mental nor endocrine. Rather that it is a combination of all these factors, acting on a soil predisposed by hereditary and environmental influences acting over a long period of time'.⁸⁷ To assess how the rich, and often diverse array of aetiological factors acted upon one another across the life history of the patient, Henderson and Gillespie wrote that the anamnesis should therefore be written in 'narrative form' so that practitioners could highlight patterns of cause and affect 'from the time of [the patient's] conception up to the alleged onset of the illness'.⁸⁸ The environmental, biological and constitutional origins of mental illness were to be put into chronological order; to be judged as they acted upon one another within the unique life history of the patient.

When reflecting upon the above quoted cases, a step-by step examination of the anamnesis highlights just how the dynamic approach de-compartmentalised and ordered the disparate events of a patient's life into a rich linear narrative.⁸⁹ Several records reveal that from these

⁸⁶ Indeed, as the decade progressed, such filiality was greatly encouraged by Henderson, as he sent a succession of his colleagues to work and train at the Phipps Clinic under the direction of Meyer. These men included Dr Ewen Cameron, Dr Angus MacNiven and Dr R. D. Gillespie, and as a letter written by Meyer to Henderson in 1927 attests, this relationship strengthened professional ties either side of the Atlantic. 'My dear Dr. Henderson. ... Cameron is a capable man, a little hard and set, but I feel, with a real advantage from his somewhat rigid attitude. He is, I think, making good effort concerning the paranoid conditions, and plans to take up a very fertile and mutually interesting topic, the guilt-feelings which will take him beyond nosological issues. Both Macniven and Cameron are definitely appreciated continuations of the Scotch component of our establishment!' On their return to Gartnaveil, these men brought with them fresh insights and a greater allegiance to the dynamic principles of Meyer. Gillespie, who had worked as Henderson's assistant before training with Meyer in Baltimore, subsequently became physician in psychological medicine at Guy's Hospital, London, and with the publication of Henderson and Gillespie's joint *Text-Book* in 1927, this became the unrivalled standard text for British students sitting postgraduate examinations in psychiatry. With Meyer's psychobiology being promulgated in such a way, it appears that Henderson's colleagues and clinical assistants gradually become more adept to the application of psychobiological, and dynamic psychiatry within clinical encounters. See Individual Correspondence Henderson, Series I, Box I/1659/12 AMC.

⁸⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp.70-71.

⁸⁸ *Ibid.*

⁸⁹ The anamnesis made possible the uniform examination of entire patient populations by a distinct set of examination criteria. Following (if somewhat adapting Meyer's clinical guides) Henderson and Gillespie

primary investigations, Henderson personally compiled a summarising analysis of patient cases, taking key elements from the anamnesis and presenting them as a single, chronological story. 'Instead of striving for endless biographies', Henderson highlighted the features of the anamnesis considered most significant to the patient's life history. Upholding Meyer's clinical teachings, the aim of the case note record was 'to give concise statements with answers to all the important questions on which we are really working'.⁹⁰

Demonstrated in the following figure 11.1-2 is Henderson's condensation of such information into a coherent, clinical narrative. It is at this initial stage in the case note record, the anamnesis was intended to furnish a report of the 'positive facts', which stood 'above or in implicit precedence to any particular interpretation',⁹¹ and therefore when enquiring into such issues as hereditary predisposition, endocrine disturbance,⁹² disease and infection, or about sexual, intellectual and emotional developments, an 'effort', wrote Henderson and Gillespie, 'should be made to record the case in simple, non-technical language' which deferred transforming the lay narrative into a 'one-word diagnosis' or a theory-laden interpretation.⁹³ Rather, it was necessary to portray the 'facts' gleaned from the anamnesis so that 'any one could come to an independent opinion';⁹⁴ so that it read as a 'continuous, consistent story'.⁹⁵

wrote that it was possible for psychiatrists to 'correlate accurately the clinical picture with other pathological findings' and 'compare cases occurring in one mental hospital with another'. Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 67.

⁹⁰ Adolf Meyer 'Special Reports of the Medical Department, Worcester Lunatic Hospital, 1898' quoted in *The Collected Papers of Adolf Meyer, Vol II, Psychiatry* (Baltimore: The Johns Hopkins University Press, 1951) p. 65.

⁹¹ Leys 'Types of One' p. 6.

⁹² Endocrine disturbances included such disorders as 'thyroid disease', 'giantism' 'dwarfism', 'obesity' and 'diabetes'. Kirby *Guides for History Taking* p. 14.

⁹³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

⁹⁴ *Ibid* p. 70. See also Leys 'Types of One' p. 5.

⁹⁵ Meyer 'Outlines of Examinations' p. 24.

Figure 11.1. 'Note by Dr. Henderson' Case no 292 GB812 HB13/5/182/2 NHSGGCA.

Note by Dr. Henderson.

[REDACTED]

This patient ^{came} to the hospital yesterday (Tuesday, 28th. August, 1923) ., accompanied by Dr. Telfer of Greenock, and also his brother, and a friend who had come with him from Rio.

His brother told me that the patient had always been a strong and healthy boy, and man, and that in 1909, or 1910, he went out to Rio to take an appointment as auditor for a London firm of Chartered Accountants. While in Rio he made an excellent reputation for himself as an accountant and was considered to be a most able man.

His further history is to the effect that in 1914 he contracted syphilis, for which he received treatment. His friend told me that five years ago he was noticed to be behaving in a peculiar way. On certain occasions he would insist on going to business even although it was a holiday, and, in addition, he seemed to forget the days and dates. His personal appearance also suffered, because he would often forget to shave himself or to put on a clean collar. In between times he had days when he seemed relatively clear and well, but at other times when spoken to about being forgetful, he tended to pass off any criticism in a light-hearted way, and it did not make any impression on him. He was extravagant in regard to money matters, and almost as soon as he had got a month's salary it would disappear.

About four months ago he complained one evening of feeling badly, and a doctor was called in to see him, who ordered him to bed, but after being in bed for four or five days he was found one morning lying on the floor as if paralysed, and his mouth was twisted. On account of this condition

Figure 11.2. Case no 292 GB812 HB13/5/182/2 NHSGGCA.

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he was taken to hospital, and is described as having been unconscious for a period of about two weeks. Since that time he has been under hospital treatment, and has had "Salvarsan" and Iron, and electric treatment and massage. As a result of this his physical condition has improved, but there has not been any betterment in his mental condition.

On the voyage home he was very pleasant and almost childish. His friend had to valet him, and it was very noticeable that he never seemed to be able to find his cabin. He has also expressed delusional ideas: thought that he had received a cheque for £800 from his brother, which was not the case, and he also tended to exaggerate, and tell some fantastic stories about elephant hunts, and about things which had never happened.

Beneath this drive for objectivity through descriptive narrativity, it is evident that as Henderson drew his dynamic principles from an array of Kraepelinian, Meyerian, Freudian, Jungian and other teachings, the anamnesis was nonetheless heavily pre-laden with interpretative meaning. Rather than the ‘facts’ of the case necessarily standing ‘above or in implicit precedence to any particular interpretation’,⁹⁶ clinical guides reveal a highly attuned methodology structured the anamnesis, and therefore the case note record played a somewhat paradoxical role.

Uniformity through the application of a pre-defined history-taking guide was essential for the formation of psychiatric knowledge; it was a prerequisite to the development of a coherent, universal set of aetiological and diagnostic criteria. Therefore, despite the subjectivity of the informant, and despite the vast array of events and environments that shaped individual cases, informants were strongly guided in their presentation of a chronological account of the patient’s life history that prioritised key diagnostic criteria such as hereditary, intellectual, emotional and sexual development. Yet, while the dynamic approach strove to promote homogeneity through the application of the clinical guide, the anamnesis simultaneously recognised the subjectivity of the informant and the individuality of the patient. Questions put forward were somewhat elastic, tailored to the informant’s own perspective, while case records went some way to obtain a detailed account of the patient’s unique personality, framed against their unique environmental backdrops.

In alignment with Foucault’s critique of patient case records, the anamnesis constructed the patient so that they could be known by their very individuality, but while the clinical encounter played a decisive role in structuring the informant’s ‘lay’ narrative, patient life histories were paradoxically circumscribed, and, to a degree homogenised by case taking outlines. As Gartnavel’s medical officers strove for objectivity through narrativity, this was only to be reached through the extensive compilation of information garnered from the family history, personal history, the account of the onset of the illness and repeated mental and physical examinations of the patient within clinical encounters. Only then could mental illnesses begin to be recognised, not simply as the result of a single aetiological

⁹⁶ Leys ‘Types of One’ p. 6.

factor, but as the ‘cumulative result of unhealthy reactions’ of the ‘individual mind’ to a set of unique environmental conditions.⁹⁷

‘On admission’

The facts obtained in the actual observation of the patient by competent physicians and nurses are naturally the backbone of the record. We pass here from second- or third hand information and memory material to the directly observable disorders, i.e., the field in which alone the physician can get his training to be able to take also second hand information critically and with sufficient sensitiveness about any possible errors and contradictions.⁹⁸

For the dynamic psychiatrist, the point at which their attention shifted from the narrative of lay informants and medical certificates towards first-hand observation of the patient within clinical settings, marked a distinct turning point in the medical record. At this point the temporality of the case note record changes from a lay, historical account of the patient to the immediate observation of the patient as they adapted to the hospital routines. During the admission in which certification forms were presented and voluntary letters signed, the waiting room signalled an individual’s legal, temporal and physical transition to institutional care, and it was from in such a liminal space that Gartnavel’s practitioners were presented with their first opportunity to capture a ‘live’ and ‘continued account’ of the patient’s story as they entered into the hospital.⁹⁹

Dynamic psychiatrists regarded this moment of transition as a valuable ‘experimental phase’. It provided one of the most decisive opportunities for Gartnavel’s psychiatrists to observe first hand the patient’s adaptive strategies to the demands of ‘a new environment’.¹⁰⁰ In accordance with the investigational techniques of Meyer, which considered each case an ‘experiment of nature’, the process of admission allowed Gartnavel’s medical officers to observe the individual adaptive strategies displayed by a patient to a set of controllable, easily replicable environmental conditions. The reactions induced in one patient by hospitals procedures could be compared and contrasted to those induced in another, and therefore the process of admission offered one of the first opportunities for Gartnavel’s medical officers to investigate the differential diagnosis of a

⁹⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. viii.

⁹⁸ Meyer ‘Outlines of Examinations’ p. 231.

⁹⁹ *Ibid* p. 237-38.

¹⁰⁰ *Ibid* p. 243.

patient under clinical conditions. Moreover, with nursing staff playing an integral role in assisting the patient through the formalities of admission (such as the signing of papers, their assignment to a ward, the bath, and the marking of their clothes), nurses' descriptions of the continual and changing effects of admission procedures upon patients was a valuable component of the medical record.¹⁰¹

As outlined by Meyer, an 'Indirect Examination' of the patient could first be made by recording the patient's 'General Behaviour' during moments when they were 'not conscious' of being under direct observation.¹⁰² 'The facial expression, the dress, the attitude', wrote Henderson and Gillespie, 'often tell at a glance the underlying state of the patient'. Noting 'at once whether there is depression, or elation and talkativeness, apathy and listlessness, co-operation or resistance' was an integral part to the case note record. Henderson advised that descriptions of the patient 'be made as vivid and telling as possible, but ... couched as far as possible in non-technical language' and therefore a richly detailed picture of the patient upon admission often derived from the dynamic approach.¹⁰³

On Admission.

When seen in the reception room the patient was sitting on the couch leaning heavily upon her sister's shoulder. Her eyes were closed and when she was spoken to she refused to answer or indicate in any that she had heard the question. After an interval however she sat up and opened her eyes and in reply to the question "how are you", she said "Don't be silly" She seemed quite composed but annoyed and very impatient at any questions asked her. She said "Leave me alone, Take me away and kill me and be done with it." She was very unwilling to give any account of herself or her trouble. She went quietly with nurse to the ward.¹⁰⁴

One of the foremost reasons for the depth of detail afforded within the case note record was clarified by Meyer as he wrote that: 'The record furnished of the history of the case up to the admission to the hospital is, as a rule, far more readable and striking than the record of what is observed in the hospital'. Meyer remarked that the principal reason for this lay with 'the difference of the stage on which the patient acts before and after admission to the hospital'. Before the patient entered the institution, it was considered that they lived and acted upon 'the stage of his ordinary life', in which 'every change and abnormality gets a

¹⁰¹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 74.

¹⁰² Meyer 'Outlines of Examinations' p. 242.

¹⁰³ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 74.

¹⁰⁴ Case Notes no. 330 GB 812 HB13/5/182/40 NHSGGCA.

bold and striking relief'. The narrative of the family informant often offered a rich and compelling tale, and as Meyer remarked, in many cases the mental reaction and its subsequent illness could not be understood with any degree of clarity until they were described in terms of the patient's former '*situation, reaction, and adjustment*'. But as patients were admitted to the hospital, the 'great experimental plane' of the world that lay beyond stood in stark contrast to the distinct, ordered and enclosed spatialities of the institution.¹⁰⁵

For patients who passed through the ornamental gates of Gartnavel it was likewise understood that 'they were in many ways 'reduced to a common level with all the others'.¹⁰⁶ Placed upon 'a strange experimental field, as it were ... the rules of the institution thwart many sallies of individuality and create uniform conditions' and this was undoubtedly enforced by the class distinctions and social hierarchies that were enforced within Gartnavel. The hospital interior removed patients from a great many of the social factors that were recognised as shaping or even aggravating their illnesses, which enabled practitioners to carry out the examination, comparison and differential diagnosis of patients under clinical conditions. But such uniformity nonetheless meant that examinations within the hospital building lacked 'an attractive setting or story'. Meyer warned that:

In the absence of a stirring train of events, the recorder of the observation is apt to lose the fundamental connections, and to write stereotyped conditions instead of giving a live continued account of an individual disease type and of illustrative changes of mental attitude.¹⁰⁷

Nonetheless with this warning in mind, one of the most significant observations made by Meyer was that the environment of the hospital could itself provoke the patient into demonstrating new and 'anomalous reactions'.¹⁰⁸ Decades before Laing was to write upon the importance of environment to patient behaviours, the 'uniformity of the hospital routine' was recognised to provoke differing behaviours among individual patients. Patients' responses to the process of admission, to 'visits', 'letters, and incidents in hospital

¹⁰⁵ Meyer 'Outlines of Examinations' pp. 237-9.

¹⁰⁶ For descriptions of Gartnavel during the 1930s to the 1990s including the ornate entrance gates that have now been removed see the written contributions of Gartnavel's past and (the then) present staff in *Reflections on the Occasion of the 150th Anniversary of Gartnavel* (Glasgow: Gartnavel Royal Hospital, 1993).

¹⁰⁷ Meyer 'Outlines of Examinations' p. 237-38.

¹⁰⁸ *Ibid* p. 238.

life', were therefore painstakingly recorded, so that a 'live and continued account' of the development of the case could be ascertained.¹⁰⁹

In accordance with the 'dynamic view' the enquiries of Gartnavel's practitioners therefore seeped into the domestic environments, the journeys, the waiting rooms and wards, which became the backdrop to patients' individual life histories. Each space was considered part of the 'pathological laboratory' to which the patient was observed to adapt, and descriptive vignettes of the admission process were considered to afford a 'natural picture of ... psychobiological maladaptation'.¹¹⁰ In the case of the aforementioned Harriet Paterson, for instance, who entered Gartnavel as a certified patient in 1924, this thick descriptive style is evidenced in her case note records. After being transferred from a nursing home, she arrived dressed in what was described as a 'flimsy evening frock' and through a cascade of tears she protested against her 'forced' admittance. Paying close attention to her statements, it is reported she regarded her father as having 'no legal right' to 'force ... her into an asylum' because she was a married woman. Still crying and showing herself 'very distressed' to the medical officers, she explained that it was not a 'legal marriage' but rather it was a 'physical marriage', a 'Scotch marriage', and 'there was nothing immoral about her'. Speaking in what was considered a 'rational' manner, she asked whether she would have a room of her own. Told that she would be made 'quite comfortable', she remarked that she had been made that promise before. In an asylum down in England where she had formerly been treated, her experiences, she insinuated, had been 'far from comfortable'. Finally, she was observed to have 'quietly' allowed the nursing sisters to lead her away from the reception room, to one of the female wards.¹¹¹

While the process of admission was considered an experimental stage upon which patients' reactive tendencies were observed, we see in the case of Miss Paterson that the emotional content of this patient's reactions was highlighted as a significant component of her adaptive strategies. Moments of resistance, ambivalence and trepidation are likewise highlighted in numerous cases throughout the decade. In the records of Patricia Robb, admitted in 1925, it was noted that it was only with a great degree of persuasion that she could be prized out of the motorcar and into Gartnavel's reception room. Once inside, she was described as speaking in a 'low unhappy tone of voice' and made several 'half hearted

¹⁰⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 74 also Meyer 'Outlines of Examinations' p. 238.

¹¹⁰ *Ibid* p. 236.

¹¹¹ Case notes no. 268 GB812 HB13/5/181/36 NHSGGCA.

attempts to leave the room' before she was led away by the nurses.¹¹² In yet another case, it was recorded that Annabel Brown, a young female patient sat in the reception room and was:

... clinging to her father, very pale faced and distressed, not demanding to be taken away, but making no move to go to the ward with sister, and expressing fear + doubt – imploring her father to give her just another minute, kissing + embracing him in a manner painful to observe. He, himself, showed much indecision of mind, encouraging her in her embraces, asking M.O. if he were sure this was the best place for her, enquiring how she would be treated etc.¹¹³

For other patients, however, their records evidence a degree of eagerness to submit to the hospitals' treatments, and this too was diligently observed and recorded. Duncan Barrowman, after being transferred from Stirling District Mental Hospital, declared that he was glad to arrive at Gartnavel as he was 'fed up' with his former co-patients.¹¹⁴ Willingness to enter Gartnavel may likewise be seen in the case of George Armstrong, a voluntary patient admitted in late-November 1925. Once Armstrong had entered the male reception room and signed the voluntary forms, the clinical clerk noted that he 'plunged straightaway into a long rambling discourse about his symptoms beginning with pimples on his anus + ending with a heat in his throat'. He stated that he was willing to pay anything up to £20 weekly for his treatment, but insisted that he have things done 'exactly as he wanted them'.¹¹⁵

While Gartnavel functioned as a 'pathological laboratory' in which to identify patients' reactions within distinct environmental conditions, it was likewise envisaged to act as a therapeutic space in which to begin to correct patients' allegedly dysfunctional behaviors. It was crucial to Henderson's therapeutic strategy that the patient recognise their condition as a mental illness, one that necessitated treatment within a hospital by medical professionals. Conforming to the hospital regime and accepting the authority of its medical staff was considered one of the first steps to therapeutic success and such a strategy therefore required that the patient adapt to the 'social reality' that was 'structured by the hospital and its attendant staff'. Demonstrated in the case above, case note records attended to the degree of cooperation or resistance shown by patients as they underwent the

¹¹² Case notes no. 297 GB812 HB13/5/182/7 NHSGGCA.

¹¹³ Case notes no. 790. GB812 HB13/5/189/34 NHSGGCA.

¹¹⁴ Case notes no. 302. GB812 HB13/5/182/12 NHSGGCA.

¹¹⁵ Ibid.

formalities of admission.¹¹⁶ Where this cooperation was gained a full and engaging narrative could often be procured from the patient in mental examinations, but gaining the co-operation of patients could evidently be problematic, seemingly lessening the therapeutic value of hospital treatment.

This is particularly noticeable in cases where patients evidenced a limited degree of realisation as to the purpose of the hospital, or the reason for their admittance. Gartnavel's nurses described one such patient, a lady admitted in 1924, who was 'very restless' on the journey to Gartnavel. When in the car she was 'getting up to look out of the window; and was 'apparently under the influences of hallucinations'. Having entered Gartnavel, she was then seen to be in a 'dull rather confused state'. She offered no clear indications that she knew where she was or that she remembered where she had come from. Her speech, it was noted 'was rather thick and her answers were inconsequent'.¹¹⁷ For a minority of patients, comments could neither be made as to their emotional reaction or to their state of cooperation upon admission, as their entrance to Gartnavel provoked no immediate reactions whatsoever. Dora MacLeod was admitted in 1925 while in a state of 'deep narcosis from administration of morphia', and it was only after several hours that she awoke within the ward, and was seen to become 'rather restless, confused and emotional'.¹¹⁸

Taking such records into account, it is evident that, while the hospital environment was considered both a pathological laboratory and a therapeutic space, case note records of the admission process served a dual function. On the one hand, as Henderson and Gillespie advocated, a rich, 'non technical' description should be made of the patient upon admission, this reflects Meyer's insistence that the signs and symptoms of mental illness meant nothing until they were analysed in relation to the 'definite setting' in which they occurred.¹¹⁹ On the other hand, with the hospital environment inspiring confidence in some of its patients, but provoking resistance, fear or confusion in others, records of admission allowed Gartnavel's medical officers to gauge patients' capacity to co-operate within

¹¹⁶ Adolf Meyer 'Therapy' *Psychobiology, A Science of Man* (Illinois: Charles C Thomas, 1957) p.162. See also Henderson and Gillespie *A Text-Book of Psychiatry* pp. 69, 537-42. Lamb *Pathologist of the Mind* pp. 114, 229, 242-3 who writes 'The Phipps environment – the confluence of its physical spaces, hospital routine and social life – served simultaneously as both a "pathology lab" in which dysfunction was investigated and tested, and a medical instrument with which to correct it'.

¹¹⁷ Case notes no. 656. GB812 HB13/5/187/56 NHSGGCA.

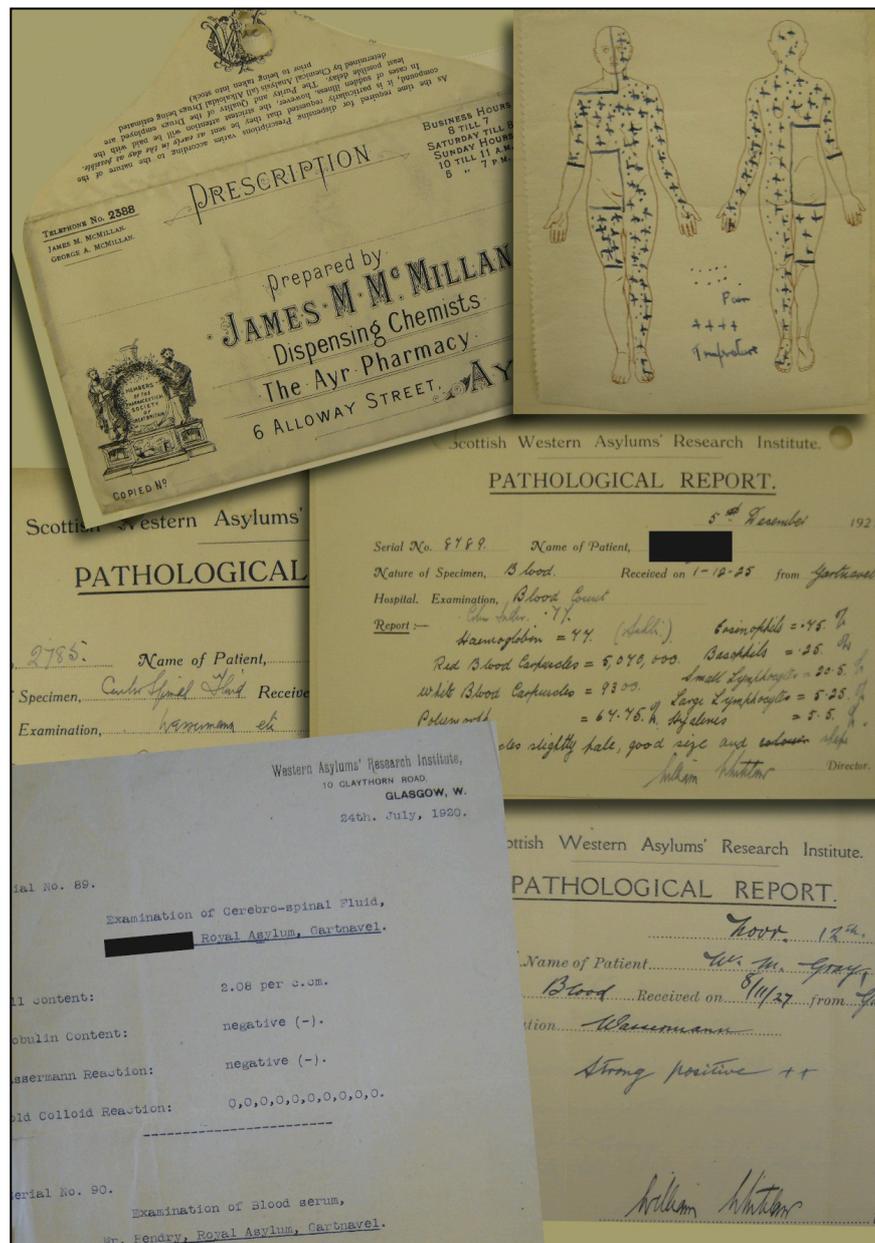
¹¹⁸ Case notes no. 299. GB812 HB13/5/182/9 NHSGGCA.

¹¹⁹ Kirby *Guides for History Taking* p. 57.

physical and mental examinations. With therapeutic ‘success or failure’ said by Henderson to depend to a ‘tremendous extent upon the degree of cooperation’ shown by the patient, observations of patient behaviours upon admission paved the way for Gartnavel’s medical officers to adjust their approach so as to ‘inspire confidence in the patient’.¹²⁰ The following section therefore explores just how the degree of cooperation or resistance was considered to alter the efficacy of treatment, while further examining the construction of the dynamic case note record within the clinical environments of the physical and mental examination.

¹²⁰ Henderson ‘Remarks on Cases Received in the Henry Phipps Psychiatric Clinic’ p. 70. See also Henderson ‘Report of the Physician-Superintendent for the Year 1921’ p. 18. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

Figure 12. Prescription notes, pathological reports and sensory examination diagrams. Taken from the case note records of the following patients: Case no 496 GB 812 HB13/5/185/31, Case no 643 GB 812 HB13/5/187/43, Case no 595 GB 812 HB13/5/186/70, Case notes 302 GB 812 HB13/5/182/12 NHSGGCA.



Part two: examination

Physical examination

Physical Condition.

She did not cooperate well in the physical examination. She was unwilling to allow it to be done. She is well nourished and of good colour.

Cardiac System. The area of cardiac dullness normal in extent. The heart sounds are pure and of good quality. Pulse, Rate 80 regular in force and rhythm. No thickening of arterial walls. B. P. 150 mmHg. Systolic and 75mm Hg. diastolic.

Respiratory System. Percussion not resonant over the lung area. Breath sounds clearly hard and normal in character.

Alimentary System. Tongue clean, teeth defective, some degree of pyrrhoea present in lower gum. Liver dullness normal in extent.

Urinary System.

Mini Sp Gr 1018 No sugar. No allumen

Nervous System. Pupils equal, respond to light and on accommodation no nystagmus present. Knee jerks equal on both sides, active. Wrist, triceps, and biceps jerks equal on both sides, all very active. Plantar reflex active on both sides and flexor in character. No ankle clonus. No patellar clonus on either side. No tremor of tongue. Slight degree of fine tremor of fingers. No disorder of articulation...¹²¹

At this point in the case note record the collation of nursing reports by a clinical clerk was brought to a close, and the direct examination of the patient by Gartnavel's medical officers began. Once patients had been allocated a ward, bathed and put to bed by nurses, Gartnavel's medical officers then took over the task of examining newly admitted patients and recording their initial observations of patients' physical and mental states.

Firstly, as was advised in the *Text-Book*, a physical examination was carried out. The physician, with the help of a nurse, tailored the examination towards the analysis of any somatic or neurological symptoms that had come to light within the anamnesis or within the first general observations made of the patient. Upon the ward and behind drawn curtains, a medical officer and an attendant nurse arranged patients' dress for the physical examination. As evidenced in case note records such as the above, patients' eyes, tongue, skin, hair, height, weight and genitalia were examined, alongside studies of reflexes and basic physical and mental aptitudes. In the above noted case, we see that with no tremor of the patient's tongue being detected, the pupils showing a good response to light and a

¹²¹ Case notes no. 330 GB 812 HB13/5/182/40 NHSGGCA.

normal 'plantar reflex', the presence of organic disease, such as that associated with syphilis, was unlikely in such a case.¹²² Similarly, as no abnormalities were detected in the sugar levels of the urinary system, the medical officer downplayed the importance of enquiring into the functioning of the endocrine glands.¹²³ Yet the patient's unwillingness to cooperate posed a problem, and it was recorded that:

She was extremely unwilling to allow a physical examination to be done. She refused to allow the chest to be examined saying that she understood this to be a mental hospital and that she did not see what examination of a patient's chest had to do with mental disease." She said she would only allow her own Doctor to examine her. The necessity of making a physical examination was explained to her but she still persisted in her unreasonable attitude. She agreed at length and asked to see the Physical Condition book. After a great deal of delay and persuasion she allowed the examination asking in a sarcastic tone as it proceeded if the M.O. could find any evidence of mental disease from his examination.¹²⁴

Given her repeated refusal to fully cooperate, her records offer a sparse and incomplete example of the notes usually derived from the physical examination. Nonetheless, this reaction exemplifies the difficulties faced by Gartnavel's physicians. 'The lack of cooperation', wrote Kirby, 'and even opposition to examination which mental patients often exhibit make the task of the physician doubly difficult and not infrequently tax severely his resourcefulness and patience'.¹²⁵ Henderson wrote of the importance of the physician gaining the trust of the patient; of employing a great deal of tact, patience and understanding within physical and mental examinations, and as evidenced above, the physician could go to great lengths to quell the objections of his patient.¹²⁶ Indeed, on several occasions, case note records demonstrate Gartnavel's physicians postponing the examination until patients (certified and voluntary) gave their consent. For example on the admission of Mary White, in 1926, she was described as being 'in such a state of terror that an adequate examination was impossible'. It was noted that she 'shrank from the M.D., and refused to undo her garments ... and when the nurse held her hands she was in definite

¹²² In the third edition of the *Text-Book* Henderson and Gillespie noted that the physical signs of psychoses associated with syphilis were, amongst others; 'Generalised tremors ... which affect particularly the outstretched hands, the tongue and the facial muscles ... changes in the pupil of the eye are often very characteristic. These consist of inequality of the pupils, irregularity of outline and, most striking of all, sluggishness, or total absence of the light reflex. pp. 299-300.

¹²³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 66.

¹²⁴ Case notes no. 330 GB 812 HB13/5/182/40 NHSGGCA.

¹²⁵ Kirby *Guides for History Taking* p. 29.

¹²⁶ Henderson and Gillespie *Text-Book of Psychiatry* (1932) p. 68.

terror'.¹²⁷ For the majority of patient case notes sampled, however, a routine examination was more readily allowed. In Kirby's guide, a more fully comprehensive examination of the patients' general state of health was recorded under the following headings:

General Type, Appearance and Condition
Thorac Organs
Digestive and Abdominal Organs
Genito-Urinary Organs
Nervous System
The Vegetative Nervous System
Endocrine Glands¹²⁸

When looking to the examinatory techniques used by Gartnavel's medical officers, contemporary *Guides* suggest that as physicians examined, for instance, the functioning of the nervous system, they might employ simple examinatory techniques such as the prod of 'the finger tip, cotton, or pin' or invite the patient to touch 'cold' and then 'warm water' held 'in a glass tube'. While attempting to provoke a patient to react to sensory stimulus, these methods were used judge a patient's 'localised sensibility to feelings such as 'touch' and 'tickle' and temperature.¹²⁹ Alternatively when investigating the state of the endocrine glands, enquiries were made into physiological abnormalities during puberty such as the 'absence of testicle; obesity' and 'feminine hair distribution' in men, or the presence of 'Delayed puberty;' an 'infantile uterus;' or 'obesity in women'.¹³⁰

In combination with a routine physical examination, laboratory tests were carried out in the vicinity of Gartnavel at the Scottish Western Asylums Research Institute, which worked extensively in the field of syphilis serology.¹³¹ The examination of cerebro-spinal fluids, blood, urine and faecal samples were all undertaken within the institute's laboratory, and therefore pathological reports may often be found pinned to patient case notes.¹³² For those patients whose symptoms indicated syphilitic infection, their case note records demonstrate that the Wasserman test was regularly used to determine the presence of syphilitic antibodies within the blood and cerebro-spinal fluids, while the 'Fuchs-Rosenthal counting

¹²⁷ Case notes no. 450 GB 812 HB13/5/184/47 NHSGGCA.

¹²⁸ Kirby *Guides for History Taking* pp. 31-40.

¹²⁹ Ibid p. 35.

¹³⁰ Ibid p. 39.

¹³¹ Andrews and Smith 'Medical Officers and Therapeutics, 1814-1921' p. 66.

¹³² Case no. 595 GB 812 HB13/5/186/70 NHSGGCA.

chamber method' was also used to estimate whether an over abundance of cells indicated syphilitic infection (see figure 12).¹³³

Once such examinations were carried out, Kirby advised that a summary of the physical findings was to be created. Symptoms recognised as being characteristic of distinct 'symptom-complex[es]' were to be grouped together, indications for treatment offered, and suggestions for further investigations to be made.¹³⁴ A notable feature of Henderson and Gillespie's *Text-Book* is that, while a picture of the possible organic aetiology of illness was being compiled, the physical examination was of great importance, not only for the discovery of organic aetiologies of mental disease, but, as previously mentioned, also to discover the 'patient's reaction to the knowledge that he has a certain disease'. Treatment was geared not only towards the 'disease alone, but the whole personality ha[d] to be taken into account', and therefore the physical examination could offer an understanding of both the physiological and psychological components of illness.¹³⁵ One such instance is exemplified in the case of Beryl Latham, admitted in 1925, whose diagnosis was 'Mental deficiency and Hysteria'. Described in the physical examination as being a female in her early 30s of 'dwarfish stature being 4ft 3" in height', with other notable physical features being her 'coarse and dry' skin, the growth of hair over her upper lip and the 'overdeveloped' state of her muscles. Her bones, it was recorded, showed 'some deformity', alongside a 'generalised slight thickening', and there was a lack of uniformity in the length of her corresponding fingers and toes.

As the examination progressed, practitioners looked back to information gathered within the anamnesis, which revealed a history of severe physical illnesses. In her first years of infancy the dates of walking and talking were delayed, and the child suffered from 'convulsions from which she nearly died'. She went to school aged eight; and, although she was frequently absent due to illness, it was recorded that she 'managed to hold her own with girls of her own age' and was an extremely popular child, looked upon as a 'droll amusing person' who, because of her frailties, was 'much petted'. Her personality was described in the anamnesis as that of a person 'who had never fully grown up ... always pleased with childish things and liked to be treated ... like a child'. During her twenties she had suffered from various ailments, including an attack of what was thought to be

¹³³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 300-301.

¹³⁴ Kirby *Guides for History Taking* p. 40.

¹³⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 66.

encephalitis lethargica (a diagnosis associated at the time with Spanish flu, which I will go on to discuss).¹³⁶ A more recent history of fainting attacks that seemingly left the patient in a semi-comatose state was also recorded. These periods of semi-consciousness were noted to last around three days, in which the patient would only ‘rouse herself to eat and to move her bladder and bowels’, but after these necessary functions were accomplished she would ‘collapse dramatically on her bed again and could not be roused by slaps or shouts’. During the year previous to her admission, she developed a paralysis of the right arm, which she ‘held stiffly at right angles across her chest’. When she was asleep or distracted, the paralysis was seen to pass off, and slowly the condition dissipated, but on her admittance to Gartnavel she was observed to show a ‘loss of power and loss of sensation in her right hand’.

Armed with this information, physicians carried out pinprick tests in the physical examination (see figure 12), which revealed numerous areas across her body that showed little or no observable sensation. Nonetheless, despite her physical illnesses and other observable physical symptoms, there appeared no gross organic defect that would account for the fainting fits, or localised anaesthetisation of which she complained. Indeed, the anamnesis revealed that, despite a series of fainting attacks, one in which she fell on a flagstone floor, she had never once injured herself, nor had she ever bit her tongue or passed urine as may occur in an epileptic seizure. It was concluded by one of Gartnavel’s physicians that, taking the results from the physical examination into account alongside information obtained with the anamnesis:

... one gets the impression of a child who owing to the invalidism of her earlier years was deferred to on every occasion. She early realised the value of her physical disabilities as a means to ensure the sympathy of others. As she grew older she began to understand that, handicapped as she was, she could never fulfil the life of a normal woman ... Her illness five years ago [encephalitis lethargica] brought before her more vividly than ever the power that the invalid [indecipherable word] and her morbid personality has succumbed to the temptation, with the result that we now find a fully established hysteric.¹³⁷

¹³⁶ Encephalitis lethargica spread rapidly across Europe, first in the winter of 1916-17 in Austria and by 1918 it had begun to spread to epidemic proportions. Contemporarily termed by the British press as the ‘sleepy-sickness’, this chapter explores the case of a patient admitted to Gartnavel under this diagnosis within the ‘Staff Meeting’ section. For more information on individuals who survived the epidemic but who then suffered from life long neurological disorders akin to severe Parkinsonism, see Sacks *Awakenings*.

¹³⁷ Case no. 496 GB812 HB13/5/185/31 NHSGGCA.

In truly Meyerian fashion, the personal history of Latham, (characterised as it was by physical illness and invalidism) was converted by Gartnavel's medical officers into a history of adaptation. Beset from an early age by physical deformity and recurrent bouts of illness, the organic aspects of her illness were easily observed within the physical examination. Yet, when the personal history suggested there was a performative aspect to her fainting attacks, the physical examination aided Gartnavel's medical officers to infer these attacks were the expression of mal-adaptation to the circumstances of life.¹³⁸ The 'hysterical fit', observed Henderson and Gillespie, 'usually occurs in the presence of others, and, in the daytime, does not involve any but very minor injuries'. Often provoked by 'an emotional situation', physical symptoms were in this sense understood as a mode of communication, and this therefore opened up Latham's case to a course of investigation that explored the emotional origins of physical symptoms and bodily performances.

Transition to the mental examination

We have to depend a great deal upon what the patient himself tells us of his story from the beginning, and should be kept to the topic with a minimum of questioning ... If the patient is allowed to tell his story in this way, it usually means that a satisfactory basis of cooperation is established, which permits of not only completing the examination expeditiously, but also gives a foundation for future work.¹³⁹

When conducting the mental examination, Henderson and Gillespie made clear the primary importance of building a rapport with the patient, and of attaining their trust and cooperation.¹⁴⁰ It was through the inter-subjective relations flowing between patient and practitioner that the mental examination became both an investigational and a therapeutic tool;¹⁴¹ thus, the ability of the psychiatric profession to explore the workings of the mind very much depended upon the patient's willingness to transform cognition into something which could be verbalised, recorded, interrogated and decoded by the psychiatric profession.¹⁴² As 'an attempt' was made to get the 'story' of the patient,¹⁴³ many willingly submitted to the examination, but as certified patients were brought into the hospital, predominantly against their will, a lack of trust could prevent the initial formation of this central dialogue. For instance in 1927, Abigail Knightly, a certified patient, was so

¹³⁸ On the subject of hysterical fits see Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 448.

¹³⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 75.

¹⁴⁰ Henderson 'Report of the Physician-Superintendent for the Year 1921' p. 18.

¹⁴¹ Lamb 'Pathologist of the Mind' p. 12.

¹⁴² Meyer 'Outlines of Examinations' p. 243.

¹⁴³ Case notes no. 330 GB 812 HB13/5/182/40 NHS GGCA.

strongly opposed to being placed in Gartnavel that '[i]t was considered inadvisable to attempt an examination along anything like stereotyped lines'.¹⁴⁴

One case that demonstrates most vividly the detrimental affect of certification upon the efficacy of the dynamic approach is that of Edmund Williamson, a married, middle-aged businessman, who was first admitted in 1920 and readmitted as a voluntary patient in 1929. In his certificates, Williamson is described as being 'exalted and excitable', 'flighty and delusive in his ideas' and 'threatening in manner' as he was observed to kick his wife in the doctor's presence. A second certificate claimed that Mr Williamson was threatening to shoot his Italian business colleague, while also relating a 'number of instances showing there is a conspiracy [by his wife and business partner] to rob him of his business'. During his initial mental examination in 1920, Williamson was asked to voice his complaint in the mental examination, to which he unequivocally replied:

"There is no complaint – I don't know why I'm here – my wife has switched me here illegally".¹⁴⁵

Williamson steered a purposeful course throughout the examination as he protested against his certification and upheld his accusations against his wife and Italian business partner. Such a conspiracy, concluded the doctor, was clearly a 'delusion'. Over the first few weeks the patient was seen to adjust 'fairly-well', gave no trouble and 'accepted things extraordinarily well', but frequently appealed to Gartnavel's medical officers to 'examine him in regard to his sanity'. His case notes record that 'all the time he fails to appreciate that he has been in a definitely abnormal condition, and that the suspicions he formed during that period have no basis in fact'.

While Williamson rejected the conclusions of Gartnavel's medical officers, both the Italian business partner and the patient's wife testified that the patient had indeed behaved abnormally during the past few months. The business partner gave a detailed history of the patient's business and personal affairs, stating that the patient had gone to see a client in his pyjamas, that he had taken heavily to drink and that once, after he had suspected his partner and Mrs Williamson of having a love affair, he 'broke open' the partner's office, 'broke into cabinets etc looking for correspondence'. One evening, as his partner and Mrs Williamson had returned together after having been at an opera, Mr Williamson was said

¹⁴⁴ Case notes no. 452 GB 812 HB13/5/184/49 NHSGGCA.

¹⁴⁵ New Case Book Series, Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

to have 'shouted out at them at the pitch of his voice 'you pair of continental f -----'. In the months that followed Mr Williamson's admission, he made numerous attempts to prove his sanity and secure his release. He admitted that, due to business and domestic worries he had taken to drink, but he stood fast in his accusations against his wife and his partner. Mr Williams' protestations gained him an independent mental examination, undertaken by a physician from Stirling Asylum. Despite this examination revealing no observable presence of organic disease, or defects of memory, thought or volition, Henderson maintained that Mr Williams remain under observation within Gartnavel as a 'convalescent patient' due to the 'delusions' still held in regards to his domestic and business affairs. Early morning in January of 1921, Mr Williamson was found to have escaped. Having obtained a screwdriver from one of the workshops, he had taken out a lower window frame and, before his absence was discovered at 7.30am, he had evaded Gartnavel's staff and regained his freedom.¹⁴⁶ The patient did not return to Gartnavel for several years, and during this time he regained direction of his business affairs. This vignette of a patient's continual resistance to the hospital regime shows some of the difficulties faced by Gartnavel's practitioners in treating patients who were forcibly admitted under certification. Further demonstrations of the polarities between certified and voluntary patients may also be seen in subsequent case note records of this patient as he returned to Gartnavel six years later.

During this time, Mr Williamson was proven correct in his assertions that his Italian business colleague was having an affair with his wife, and it was confirmed by one of Gartnavel's medical officers that they had 'conspired' to 'have him certified insane and locked up in order to get off with his money'. After having regained his business and divorced his wife, Mr Williamson built afresh a new and successful enterprise. But in time he found his workload begin to slacken, and mirroring the former assertions made by his ex-wife that he was an alcoholic, he begun to take to drink. Escalating to the consumption of a bottle of whisky a day, he retreated from his business affairs and sought seclusion from society. The day before his voluntary admission, he felt that 'detectives were on his track'. He reflected in conversation to one of Gartnavel's practitioners that at this time he had 'felt sure they wished to take him back to the asylum', and that he had 'made up his mind that he would rather kill himself than submit to a repetition' of his earlier treatment. His attempted suicide, wrote Gartnavel's practitioner, 'undoubtedly would have

¹⁴⁶ New Case Book Series: Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

succeeded' had he not been 'so weak and confused due to alcohol, lack of food, and lack of sleep'. When Mr Williamson was revived, he came to the realisation that 'there was no plot against him', and after being advised to return to Gartnavel he voluntarily submitted himself to Dr Henderson's care. This time it was recorded that Mr Williamson 'cooperated in all his treatment', that he discussed his condition with 'insight' and showed a 'well balanced mind'. In regards to Dr Henderson who had presided over his case in 1920-1921, it was recorded that the patient wished 'to go fully into his care', and that he bore 'no malice for his former detention' despite holding the opinion that his former detention was 'criminal'. In less than a month, Mr Williams was discharged 'Recovered'.¹⁴⁷

Internal setting of the mental examination

Of course it was not only the conditions surrounding admission that impeded cooperation. Case notes evidence that a lack of cooperation was also due to the more intimate, tangible environment of the clinical encounter, which proved in many ways an uncondusive setting for mental examinations. For example, during the initial interview, patients often remained within their dormitory beds. Surrounded by other patients and ward nurses, the open dormitories that housed many of the East House patients necessitated that curtains be drawn around the interviewer and interviewee.¹⁴⁸ With mental examinations being conducted in such a public place, behind only the flimsiest of partitions, it was recorded that one patient, named Harriet Smith:

... showed a natural anxiety that what she said was not overheard by anyone else in the ward. At one point in the examination she asked anxiously if anyone saw the report and said she did not like notes being taken of what she said.¹⁴⁹

¹⁴⁷ Case no 643 GB812 HB13/5/187/43 NHSGGCA. Whilst this is an extreme example of a patient's resistance to Gartnavel stemming from the conditions of certification and forced admission, it nonetheless provides support to the argument, contemporarily voiced by Henderson, that the cooperation and successful treatment of a patient depended to a great extent upon voluntary admittance. During his time at the Henry Phipps Psychiatric Clinic, Henderson wrote that 'success or failure in the treatment of a case depends to a tremendous extent upon the degree of cooperation' shown by the patient. He therefore advocated that general practitioners and lay members of the public facilitate the admission of patients on a voluntary basis before the onset of illness decreased the patient's capacity to cooperate. Henderson regarded the lack of voluntary patients to Gartnavel in the early 1920s as a great social problem. He argued in 1921 that mental hospitals were recognised by the public as 'an eyesore', as 'simply custodial institutions' rather than 'true hospitals' and that this proved a great social barrier to the early admission and successful treatment of Gartnavel's patients. Henderson 'Remarks on Cases Received in the Henry Phipps Psychiatric Clinic' p. 70-72.

¹⁴⁸ A description written by a physician of an interview with a newly admitted patient that he conducted upon a ward 'behind screens' was recorded in New Case Book Series: Females, Vol 28, HB13/5/176 NHSGGCA.

¹⁴⁹ Case notes no 426 GB 812 HB13/5/184/23 NHSGGCA.

The act of questioning and note-taking was itself sometimes seen as a great intrusion. The process of transforming patient narrative into a written statement of fact seems, in a number of cases, to be looked upon by as a threatening, disempowering process. The words used by medical officers to provoke and to contextualise patient narrative were, on occasion, criticised; while the right of the medical officer to conduct such examinations were sometimes challenged. Robert Norton, admitted 1926, was recorded as having ‘rather resented being asked questions’:

He ... discussed the way in which the questions were put, was suspicious of my motives in questioning him, and he refused to allow me to take any notes. He said that if I took notes that he would refuse to speak to me at all ... He constantly repeated the questions I asked him, he found fault with it in various ways, he complained about the manner in which it was asked, he took exception to the way I sat on a chair besides his bed, and eventually he refused to cooperate any further, finishing up by saying that he considered I was just as insane as he was.¹⁵⁰

For patients who would not, or could not, relate their story in full, Henderson wrote that psychiatrists might nevertheless obtain ‘sufficient’ information upon which to ‘base an independent opinion’ of the case from patients’ limited responses to questioning,¹⁵¹ and therefore medical officers could explore some of the more ‘accessible facts’ such as ‘affect and emotion’, orientation, or comprehension.¹⁵² Douglas Aitken, for instance, who was admitted in 1924, spoke in the mental examination ‘with something of a great effort as if his attention had to be ~~to be~~ dragged away from his hallucinations’. Records state he was ‘reluctant to tell his story’ and ‘in response to most questions he would laugh, smile and mutter unintelligibly’. However, despite Aitken’s poor verbal response, the recording medical officer described in detail the affective and the performative nature of his actions. His laughter, we are informed, disrupted the medical officers line of questioning, while Aitken was seen to be ‘deliberately exaggerating his squint’ when looking at the ‘M.O.’¹⁵³

These non-verbal forms of communication, which disrupted the flow of the mental examination, will be looked at again in the following discussion. However, for those patients who acted co-operatively during the mental examination, their mental

¹⁵⁰ Case notes no 398 GB 812 HB13/5/183/54 NHSGGCA.

¹⁵¹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

¹⁵² Case notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

¹⁵³ Case no 282 GB812 HB13/5/181/50 NHSGGCA.

examinations followed a more systematic line of questioning. Case taking guides advised that medical officers begin the examination by assessing the patient's 'Stream of Mental Activity', commencing to study patients' 'Emotional Reaction (Affect)', their 'Mental Trend: Content of Thought', and their 'Insight and Judgement'. This was to be followed by some of the more easily measurable aspects of mentation such as 'Orientation', 'Memory', 'Comprehension' 'General Knowledge' and 'General Intelligence'.¹⁵⁴ By ordering the mental examination thus so, the medical officer imposed structure and uniformity to mental examinations. The degree to which this structure was upheld, however, was often dependent upon the contents of the patient's speech and their non-verbal reactions, which likewise swayed the directional flow of conversation.

Case note records of the mental examination therefore range from a concise ordering of the patient-practitioner conversation under the above headings, to more sprawling and diffuse accounts. However, for the sake of comprehensibility, my analysis strips away some of these irregularities. Excerpts taken from mental examination records will be presented under the headings noted above, such as 'Stream of Mental Activity', 'Emotional Reaction (Affect)' and 'Mental Trend: Content of Thought', as originally laid down in Henderson and Gillespie's *Text-Book*. By separating out and studying in isolation these particular elements of the mental examination record, I tease out those moments when patients' responses were thought symptomatic of unhealthy mental reactions. In doing so, I once again perform somewhat of an unnatural dissection of the case note record, whereby constituent elements of the examination are presented in isolation from the entire life history. While this explicitly goes against the ethos of dynamic psychiatry, the remainder of this chapter endeavours to show how behaviours thought symptomatic of mental illness were gradually collated in the case note record. By further understanding the ways by which Gartnavel's medical officers, and indeed patients themselves, distinguished abnormality from normality, the remainder of this chapter looks to the surface reactions, and immediately recognisable symptoms, that alerted patients and medical officers to underlying mental problems.

¹⁵⁴ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 74-80.

Stream of mental activity

First, to explore systematically the ‘Stream of Mental Activity’, Henderson wrote that this could be ‘easily and quickly determined by a number of simple questions e.g. “What is your name in full?” “Are you married or single?”, “How old are you?”, “What is your occupation?” and “What do you complain of?”’ If the patient’s speech was characterised by the erratic flight of ideas, slowness of pace, moments of emotional exaltation, incoherence, repetition of words and phrases, or by periods of silence, then verbatim samples of such irregularities were recorded so as to build up the symptom picture.¹⁵⁵ A range of psychological complexes and organic diseases were recognised as exhibiting distinct characteristic features in patient speech, and therefore any irregularities were carefully recorded for future analysis.¹⁵⁶

In alignment with contemporary psychoanalytic and psychological practices, case note records evidence practitioners used headings and descriptive terminology such as ‘distractibility’, ‘blocking’, ‘disconnection’, ‘word salad’, ‘scattering’, ‘punning and rhyming’, ‘neologisms’ and ‘fragmentation’, to focus upon the interrelationship between patients’ thoughts, feelings, and their linguistic expression within the external world. For those patients whose ‘Stream of Mental Activity’ was noted to be lucid and coherent, this state often pointed towards the absence of organic disease or acute psychological disorders. But for other patients, the inability to voice a coherent narrative was often a cue for further investigation. In the case of Duncan Barrowman, whose disorder was believed to stem from ‘Shell Shock commotion’, his record evidenced a marked disturbance in his stream of his thought:

Patient was found in bed turning about in a restless manner. He was strange when spoken to and said he could not answer any questions as he was feeling confused. A few seconds later he said he felt all right + was prepared to speak to me and answer any questions if wished to put to him. He declared that he was unable to say how he felt but was inclined to be afraid and to feel confused – not all the time but at intervals.

When allowed to tell his story he is very apt to get confused + to lose the thread of what he is saying.¹⁵⁷

¹⁵⁵ Ibid pp. 74-76.

¹⁵⁶ Ibid pp. 84-85.

¹⁵⁷ Case no 302 GB812 HB13/5/182/12 NHSGGCA.

Another patient who tested positive in the Wasserman reaction was recording as having responded to the mental examination in a very ‘distractible’ manner, ‘talking continuously going from one subject to another’,¹⁵⁸ whilst for Douglas Aitken, diagnosed as dementia praecox, it was noted that:

When ordinary conversation on any ... subject is attempted, it is found that he cannot enter into it, almost at once reverting to the subject of the German spy. Occasionally conversation even on this subject is disconnected, + sometimes quite unintelligible. He yawns, whispers to himself, hisses, etc.¹⁵⁹

Emotional reaction (affect)

While these initial observations were made, ideas expressed by the patient could point towards their emotional, or affective state, and therefore the examination could progress from the ‘Stream of Mental Activity’ to that of a patient’s ‘Emotional Reaction’. Emotional ‘abnormalities’ wrote Kirby ‘are among the most striking manifestations of mental disorder’ and therefore enquiries were to be directed towards the ‘relation [of emotion] to the ‘mental trend and general activity of the patient’.¹⁶⁰ One instance of this transition from analysing the stream of mental activity to analysing affect is taken from the case notes of Martha Little who was admitted in July 1925. Within this patient’s mental examination, dislocation between the psychiatrist’s line of questioning and the patient’s own thoughts and concerns produced a diffuse dialogue. The stream of her conversation was fixed, revolving around the repetition of thoughts and ideas, and therefore the medical officer recorded how the free flow of the conversation jarred, in many instances falling apart, as the patient broke away from the psychiatrist’s line of questioning.

Continually asserting that she could say no more than her often-repeated phrase that she was “‘absolutely dead’, the medical officer progressively steered the examination away from the patient’s stream of mental activity, to that of affect and emotion:

The more I am eating the more I should be destroyed. Oh, Doctor, wrap me in a blanket, and take me by the head and feet, and throw me in the ashpit. I am just a dirty wee wretch. I have gone with Satan instead of God; tie me up in blankets and

¹⁵⁸ Case no 285 GB 812 HB13/5/181/53 NHSGGCA.

¹⁵⁹ Case no 282 GB812 HB13/5/181/50 NHSGGCA.

¹⁶⁰ Kirby *Guides for History Taking* p. 63.

cover my nakedness and throw me in the ashpit, a poor wretch.”

- E. What do you mean by “going with Satan instead of god”? What did you do wrong?
- P. I did no sin at all. I destroyed myself; my inside is all away.
- E. How did you do that?
- P. I can’t tell you; I don’t know myself. I have been examined and examined and examined. I can’t say any more.
- E. How can you be dead when you are talking to me, and seeing me, and hearing me?
- P. Take me by the head and feet and throw me in the ashpit. What is the use of doing this? Take me by the head and feet and throw me in the ashpit; it’s all you have to do.
- E. But you aren’t really dead?
- P. Don’t talk rubbish. I haven’t a pin-point to stand on...
- E. How do you feel?
- P. I feel I’ve destroyed myself; I am absolutely dead and I will never die. I am absolutely dead and I haven’t a pin-point to stand on ... You’ve reported, and reported, and reported, and all you have to do is to take a poor wee dirty wretch by the head and feet; that is all that you have to do.¹⁶¹

To comprehend the emotional state of the patient, Kirby wrote that ‘objective’ observations could first be made, noting such things as the ‘facial expression, the attitudes and postures’.¹⁶² Dissociation between the patient’s ‘ideas and the accompanying mood’ was likewise considered indicative of mental disorder, with reference to an ‘indifferent, smiling, or silly reaction in the face of ideas which would normally call forth a depressive, anxious, or distressed affective response’. In the case of Agnes Sneddon, admitted in 1926, disharmony between her thoughts and emotions were noted as it was recorded:

Many of her statements showed a complete inco-ordination between mood and thought content. Sometimes she actually laughed in response to her hallucinations; ... Following is verbatim:

M.O. “How are you” Pat: “Very [word lost] ... thank you. The last spoken syllabically and rather slowly: the pause approximated 8 secs...

M.O. ‘Are you fairly well?’

Pat: “Quite well thank .. you.

M.O. “Are you happy?”

Pat: “I am” ... (she laughed to herself.) ...

M.O. “Something is making you laugh?”

Pat “Yes” She coughed, then laughed.

¹⁶¹ Case notes no 425 GB812 HB13/5/184/22 NHSGGCA.

¹⁶² Kirby *Guides for History Taking* p. 63.

M.O. "What's the joke?" ...
 Pat. "Eh, I need to go to the Dentist".
 M.O. "That's not normally considered a joke"
 Pat. "It's pain to me, its torture; in this state of nerves, it's torture."...
 M.O. "Are you hearing voices".
 Patient nodded
 M.O. "What are the voices saying?" patient sighed; no reply.
 M.O. Rpt".
 Pat "Pyorrhoea". A disquieted expression passed over her face and then she smiled.
 M.O. "But that's not a thing to smile about."
 Pat. "Its painful".
 M.O. "Why are you smiling and happy?"
 Patient passed her fingers round her gums but said nothing.¹⁶³

This case note record shows the tendency of Gartnavel's medical officers to preserve verbatim samples of patient narratives which evidence notable disorders of thought and affect. To describe the patient's affective state merely through the use of terms such as 'happiness, sorrow' and 'anxiety' was considered a poor approach to case note taking. The 'language of emotion' was often considered inadequate for the representation of affect, and therefore verbatim samples were commonly used to contextualise and thereby give meaning to patients' affective states.¹⁶⁴ To overcome the limitations of language, Henderson advocated that the medical officer record a detailed description that included the patients' immediate affective state, and also the 'depth, duration, and setting' of these feelings. 'The points which have particularly to be kept in mind', wrote Henderson and Gillespie, 'are the intensity of the affect, whether it varies, the response to reassurance, and the question whether it is in harmony with the ideas expressed'. Affect was in many ways considered to lie outside of the psychiatrist's immediate field of observation, and hence Henderson wrote that 'We have to depend a great deal upon what the patient ... tells us regarding his feelings'.¹⁶⁵

To begin this line of questioning, practitioners were advised to enquire into the general feelings of the patient, and to ask simply 'How do you feel?'. Henderson and Gillespie proposed that 'It is a false move and a great insult' to ask a patient who was clearly depressed whether they were happy, and therefore it was considered best to open enquiries with a general question before tailoring the examination in accordance with the patients'

¹⁶³ Case no 775 GB812 HB13/5/189/19 NHSGGCA.

¹⁶⁴ Henderson and Gillespie *A Text-Book of Psychiatry* pp. 86-87.

¹⁶⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 74-76.

replies.¹⁶⁶ As the examination progressed questions were steered towards the thoughts producing, or which gave meaning to, the patient's emotional reactions. Thus, in one case, the patient intimated the presence of hallucinatory experiences that provoked an emotional response within the mental examination. Asked if anything was worrying her, she replied:

I don't know – at the window here. I heard every distinct figure moving. The ~~sn~~ crawled down my night dress. It was like a tube. It goes down as far as my toes. I just keep my knees up in order not to allow anything to happen.

Does this frighten you? A: Yes.

What are you afraid of? A: I am afraid of being killed

Why? A: There are so many guns going off (she began to weep)

Why are you crying? I think living here will make me so frightened. I would rather be at home. Sitting so close to the window they seem to jamb my hair.¹⁶⁷

For the majority of patient records sampled, enquiries into their emotional state produced detailed and illuminating insights into their phenomenological worlds, but many patients could not, or would not, speak about their feelings. For patients who remained 'unresponsive or mute', Henderson and Gillespie suggested Gartnavel's practitioners could 'approximately gauge the affective state' through other means. As well as the emotional content and tone of patients' language being observed, bodily manifestations of affect were also noted 'such ... as pallor, flushing, perspiration, the respiration rate and the pulse'.¹⁶⁸

One case, in which Gartnavel's medical officers combined an examination of affect with the observation of a patient's physiological state, concerned a former nurse named Elizabeth Brown whose anamnesis recorded a history of morphine addiction. Analysis of the psychological effects of withdrawal began with the patient giving a description of her emotional state. She informed the practitioner that she felt 'jumpy', 'ready to cry at the least provocation', the complete opposite of the 'pleasant contentment' experienced when taking morphine. When taking the drug, she felt disconnected from her surroundings, but, once deprived, she felt her surroundings 'affect[ed] her strongly', so much so that she could not sleep, her mind was so active. As the examination progressed, both psychological and organic components of affect were studied, and therefore the sensation of *reawakening*, of her mind becoming acutely aware of her surroundings, was recorded alongside observations of the more tangible, toxic effects of withdrawal. Within the

¹⁶⁶ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 76.

¹⁶⁷ Case no 483 GB812 HB13/5/185/18 NHSGGCA.

¹⁶⁸ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 74-75.

examination, it was noted how she ‘perspires freely, and ... suffers from periods of palpitation’; tremors, understood to stem from a ‘temporary toxic process affecting the brain’, were seen to afflict her body. Such visceral reactions were reckoned to stem from the body’s reaction to the drug, and yet her symptoms were seen to present a more complex aetiological picture when both organic and psychological components of affect were taken into account. ‘The more intimate part of the environment constituted by the body’, wrote Henderson and Gillespie, ‘has important relations to the mind’.

... mental events (ideas) are followed by bodily (physical) events in so regular and invariable a way that a relationship of cause and effect is universally assumed to exist.¹⁶⁹

While the patient’s organic symptoms stemmed from toxic reactions, Gartnavel’s medical officers observed them to be aggravated by the patient’s psychological condition, the tremors being more pronounced ‘if she is emotionally upset’. ‘[M]ental events’, continued Henderson and Gillespie, ‘which have an emotional accompaniment have a bodily reverberation also, not in the form of directly adaptive movement ... but in the form of disturbances of function ... e.g. tremors’. These bodily reactions, they suggest, draw the patient’s attention to their self; to their frustrations and emotions, which in turn heightens the overall affective state. Therefore, as affect was judged in its relation to both organic and psychological reactions, this patient’s case note record evidences the ‘vicious cycle’ recognised to exist between mind and body.¹⁷⁰

Such responses enabled Gartnavel’s practitioners to gauge patients’ affectual responses to organic and psychological factors within the hospital environment, but for Henderson and Gillespie the site of investigation lay, in many cases, outside of the clinical arena. ‘[W]e want to analyse more deeply not only the affect’ wrote Henderson and Gillespie, ‘but also the situation producing it, whether it is dependent on domestic, social or business difficulties’.¹⁷¹ ‘It often happens’, they continued, ‘that when a patient is describing his “feelings” he will express ideas pointing to a disordered content of thought’.¹⁷² It was at this moment in the examination that the case note record moved from an analysis of a patient’s immediate affective state, to enquiries aiming to ‘deepen’ an understanding of

¹⁶⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 113.

¹⁷⁰ Case notes no 448. GB812 HB13/5/184/45 NHSGGCA.

¹⁷¹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 74-76.

¹⁷² Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 77.

emotion by uncovering the ‘origin and elaboration of any peculiar ideas, abnormal trends, special undercurrents, and hallucinatory experiences’ in the patient’s content of thought.¹⁷³

Mental trend: content of thought

This transition, from an examination of the patient’s immediate affective state to the analysis of the content of thought, may be seen in the case of a female patient named Marjorie Fullerton, admitted 1928. Within the mental examination, Miss Fullerton was initially asked to relate her feelings, and to this she replied: ‘I’m very unhappy. These thoughts – and feelings – torture me’. Noting her physical state, the practitioner remarked that ‘She looks unhappy and worried. She holds her head. She speaks flatly’. Words, the practitioner stated, ultimately failed him: ‘One cannot describe a visible emotional loss’. Rather than offer a merely descriptive account of her emotional state, the practitioner encouraged his patient to look back to the events in her life when her feelings began to change, and the examination moved firmly to the assessment of the patient’s ‘Mental Trend : Content of Thought’. The patient revealed that several years previous to her admission she had fallen from a bus, after which she noticed a great deterioration in her intellectual abilities and emotional state. Her head, she declared, had become sore. Formerly a primary school teacher, she could no longer concentrate on her work, and so she left her employment to take up domestic duties in her family home (an occupation her brother stated in the anamnesis, was strongly disliked by his sister). After a period of relative improvement in which the patient returned to teaching, she stated that she began to ‘feel that people were looking at her’. Formerly having interests outside of her work and the home, she now left her teaching position and began to seclude herself indoors. It was then that ‘somatic hallucinations’ began to plague her mind and body. She described to the practitioner having experienced the:

[F]eeling as if a sack of coals was suddenly laid on her back and after a time fell off, [also] a sensation of being gripped by an invisible hand at various points of her body ... She also felt that her thoughts were being read by the neighbours who had an electric machine for the purpose. The sudden coming into her mind of filthy thoughts and foul words dates from this period.

Questioning the patient whether her loss of employment had ‘been a blow’, or whether her home situation had proved ‘repugnant to her’, her response was considered abnormally

¹⁷³ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 76-77.

apathetic. Guided to reflect upon her transition from a job successfully carried out since she was a schoolgirl to a domestic lifestyle to which she was temperamentally unsuited, her reply was one of indifference. ‘Incongruity and disharmony of affect - inappropriateness of affect to thought content’, these were the factors considered symptomatic of mental illness.¹⁷⁴ As her case note records progressed over the next few weeks, her symptoms were seen to worsen and further enquiry revealed she felt ‘as if she was made of glass’, and that she ‘felt a loss of flexibility and transparency’. “I cannot think straight”, she stated, as an external influence was felt to affect her thoughts, although she could not say who was responsible for it.¹⁷⁵ ‘Her whole attitude’, the psychiatrist continued, ‘show[s] a break up of her personality’. Glass, being brittle and inflexible, was thought to symbolise a ‘loss of affect’, while its transparency exposed her feelings and thoughts as though ‘known + interfered with’. ‘[S]he is lack-lustre and careless’ noted the physician ‘and even when discussing her troubles she shows a lack of affect indicative of an internal life which has little to do with the world around’:

She repeats that she has done nothing wrong and that her “forced” thoughts are foreign to her nature but repeated efforts failed to get any indication of what the ideas are. All she would say was that the thoughts were of “men in the house” and she said that there had never been anything of that kind ... She refers to them as ‘hallucinations’ and says that she never had them until two days before her admission here. Before that she had only the feelings of somatic interference already mentioned.¹⁷⁶

Converting both linguistic and affective reactions into a symptom picture is seen in this case to have required a mode of interpretation akin to that of semiotic enquiry.¹⁷⁷ It was at this stage in the mental examination, when a more complex picture of illness was forming, that printed guides gave precise advice as how to analyse the patient’s ‘Mental Trend: Content of Thought’. In the *Text-Book*, Henderson and Gillespie advised that the language and behaviours of the patient be broken up into an array of characteristic groupings, each of which held diagnostic meaning. In alignment with Kirby, enquiries were to be compiled which detailed the presence of: ‘persecutory’ ideas, ‘nihilistic’ or ‘depressive trends’, ‘grandiose ideas’, ‘compulsive thought or action, or obsession’, ‘passivity’ or ‘hallucinatory experiences’. Once evidence of abnormalities such as the presence of

¹⁷⁴ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 86-87.

¹⁷⁵ Case no 655 GB812 HB13/5/187/55 NHSGGCA. Interview dated 24th December 1928.

¹⁷⁶ *Ibid.*

¹⁷⁷ I use the term semiotics to infer the deep hermeneutic level of enquiry, made by Gartnavel’s practitioners, as they quarried the language and behaviors of patients so as to unearth their symbolic meaning.

delusion or hallucination was elicited, Henderson and Gillespie believed that the examining medical officer must extract a detailed account of ‘how, why and when such disturbances appear’. If the patient described any compulsive thoughts or actions, it should be determined whether these thoughts ‘come with insistent force into the patient’s mind, and dominate completely’ and whether these actions had to be ‘repeated’: was there any ‘ritual’ associated with ‘daily tasks?’¹⁷⁸

Throughout the sample of case note records taken from this ten-year period, records of the ‘Mental Trend: Content of Thought’ reveal a variety of such symptoms, drawn out from the stories of patients. With Gartnavel’s medical officers highlighting some of the most notable features of the patient’s narrative, the following samples, (a far from exhaustive representation of case note materials) exemplify how patients’ narratives were contextualised and categorised in alignment with case-taking guides.

Hallucination

‘Hallucinations’ wrote Henderson and Gillespie ‘are mental impressions of sensory vividness occurring without external stimulus’. These sensory impressions occurred most often in the form of visual or auditory hallucinations, but could also occur as hallucinations of smell, taste, touch or psychomotor disturbances in which the body feels as though moved by some external force.¹⁷⁹ At this stage in the mental examination it often occurred that medical practitioners merely scratched the surface, unveiling snippets of a much larger reaction type, which only repeated interviews and further analysis could unveil. Nonetheless, detailed descriptions of hallucinatory experiences did occur within these initial mental examinations and, as the following examples make clear, the contents of such experiences intimate towards the memories, emotions, thoughts and environments, that gave these experiences meaning.

Visual hallucination

Beginning with a series of cases in which visual hallucinations were present, the case of Dora MacLeod demonstrates the presence of visual, alongside auditory and psychomotor,

¹⁷⁸ Kirby *Guides for History Taking* pp. 64-68. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 77-78.

¹⁷⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 91-94.

hallucinations. In the mental examinations, she reports that during the night she sometimes experienced a sensation as though electricity were passing through her body. This sensation, she states, 'made her feel that her life was going to be crushed out of her'. On one occasion she describes having lain awake at night while she watched a shadow on the dormitory wall. The 'voices', it was recorded, told her that the shadow was that of her daughter:

The figure was clothed in white and had a band round its head. She was fair haired just like her daughter. She saw another shadow through the door. It was that of a figure covered with blood ... She thought the figure was Jesus. She was frightened at the presence of this figure although she tried not to be.¹⁸⁰

Visual hallucinations were likewise present in the case of a male patient named Roy Mackinnon, admitted in 1929, whose records stated that, 'regarding hallucinations', the patient had admitted to having seen a lady dressed in black who 'comes into his bedroom at night when he knows he is not asleep'. When he did dream, he envisaged a lady with long hair sitting at the side of his bed. His records state that he had the impression that she was 'just wondering, wondering: she said nothing'.¹⁸¹ Another patient named Gladys Bertram, admitted to Gartnavel in 1926, was described as varying between two states. At times she was 'extremely hallucinated', so absorbed in her thoughts that she gave no notice to external events, while at other times she was pleasant, answered the questions of the medical officer and yet 'tended to drift back to her hallucinated condition'. Two days after her physical examination, a clinical clerk wrote that when the medical officer attempted to talk to her, she was seen to look towards 'hallucinatory personages'. She then called out to them, saying that a thunderstorm would come and 'wipe out the M.O.'.¹⁸²

Hallucinatory projections with passivity

Within the case notes sampled, a small number of records occur in which thoughts, termed by Meyer as feelings of 'passivity', were expressed by Gartnavel's patients. Often these ideas gravitated around the sensation that someone reads their thoughts, that they were 'hypnotised' or 'being made to think or do things'.¹⁸³ For Charlotte Keir, admitted in 1929,

¹⁸⁰ Case notes no 299 GB812 HB13/5/182/9 NHSGGCA interview dated 8th February 1925.

¹⁸¹ Case no 654 GB 812 HB13/5/187/54.

¹⁸² Case notes no. 775 GB812 HB13/5/189/19.

¹⁸³ Adolf Meyer 'Leading Concepts of Psychobiology (Ergasiology) and of Psychiatry (Ergasiatry)' first published in the Appendix to the *Proceedings of the Fourth Conference on Psychiatric Education* by the

she told the medical officer that she had been developing the art of 'clairvoyance', and that 'she had succeeded once or twice'. She had seen 'Mr Stead, Tennyson, and on one occasion a dark figure'. Since she 'got "over"' to the spiritual world, she told the medical officer that 'she has had a feeling in her throat, like wireless'. Feeling as though she acted as a medium, she felt she was being used for some purpose; 'messages', wrote the medical officer, were believed to be 'sent through her' that 'go out into the world'.¹⁸⁴

Another patient named Stanley Barnes, admitted in 1924, revealed within the mental examination that he believed himself not to be Stanley Barnes, but rather a Dr MacMillan, a man who merely inhabited the body of Barnes. After a 'prolonged interrogation', the patient stated that after he received a blow on the head in January 1921: "[Barnes] and his mother came to see me about a wound on ... his head". The patient was asked to confirm that the wound was inflicted on Barnes' head. 'Yes', replied the patient. After yet more conversation, it transpired that the patient believed himself under the influence of X-rays put on him by Dr Macmillan on the day that he consulted him about his head injury. It was by means of 'X ray' that the patient believed Dr Macmillan had 'got inside him', and was now 'speaking with [Barnes'] lips and looking through [Barnes'] eyes'. It was obvious, related the medical officer, that the patient was also having auditory hallucinations.¹⁸⁵

Delusions of persecution

In some cases, hallucinatory symptoms were observed to act upon the patient alongside the presence of other delusional, persecutory or otherwise 'peculiar ideas' and 'experiences'.¹⁸⁶ A delusion, wrote Henderson and Gillespie, is 'a belief that is (a) not true to fact; (b) cannot be correct by an appeal to the reason of the person entertaining it; and (c) is out of harmony with the individual's education and surroundings'. Delusions were rarely considered to demonstrate an isolated problem, but were rather indicative of a 'deep-seated and widespread disorder'. The delusion, postulated Henderson and Gillespie is as 'a small island is but the summit of an immense mountain rising from the floor of the sea, so a

National Committee for Mental Hygiene, 1938, 267-301. Republished in *The Collected Papers of Adolf Meyer Volume III Medical Teaching* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) p. 304.

¹⁸⁴ Case notes no 690 GB812 HB13/5/187/90 NHSGGCA.

¹⁸⁵ Case no 282 GB812 HB13/5/181/50 NHSGGCA.

¹⁸⁶ Kirby *Guides for History Taking* p. 65.

delusion is merely a component part of a mental disease, extending, it may be, to the very foundations of the mind'.¹⁸⁷ Defining delusions thus, the following excerpts demonstrate the complex, multi-layered collation of delusionary and hallucinatory experiences within case note records.

Upon the arrival of Beryl Patterson in November 1924, she was so insistent that the medical officer heard about her persecutory ideas that a preliminary mental examination began right there and then within the reception room. It was recorded that she 'poured out a stream of words which were often impossible to follow', but from what could be made out it became clear that she spoke in relation to 'the persecutions' which she felt she was suffering. Stating that the police and others were 'inoculating her with disease', she expressed the belief that the police - at least within her own home - overheard everything she spoke of. While this conversation went on, a voice, unheard by anyone in the reception room except the patient herself, was heard to say "I'll smother you; you've syphilis." She stated to the medical officer that these people who overheard her, most especially the police, were wetting her clothes 'so that she was not clean'; they put things on to her clothing, dirt was mentioned especially, and she stated that these persecutory figures were actually there within the reception room, 'putting darts into her feet'.¹⁸⁸

Grandiose ideas/delusions of grandeur

For other patients, there was the expression of 'Grandiose Ideas'; feelings of heightened power, wealth, social standing or importance. Delusions of grandeur and delusions of persecution, noted Henderson and Gillespie, were frequently found together and were often 'compensatory for failure in some direction'. In other cases, Henderson and Gillespie wrote that the foundations for the delusion were less obvious, with 'psychoanalysts' postulating that such ideas stemmed from 'a repressed homosexuality'.¹⁸⁹ Richard Govan, whose case notes demonstrate the classification of delusions of grandeur, was admitted in November 1927. After being asked in the mental examination if his 'head' felt 'all right' Govan replied that his head was 'Perfect: clear' and that 'He will always be able to do business'. The medical officer noted that he talked about being 'the greatest man the world has ever seen'. The reason given for this claim was because of his 'life, conduct +

¹⁸⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 90.

¹⁸⁸ Case notes no. 319 GB812 HB13/5/189/29 NHSGGCA.

¹⁸⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 91.

relationship with humanity + because of his love for nature'. When asked whether he was a rich man, the patient replied 'I haven't a penny in the world – I'm the richest man in the world'.¹⁹⁰ Another patient, who had fought 'at the front' during the First World War, stated in the mental examination that 'the next war would, because of him, be more human, w.d. result in better things, more beauty'. He said to the medical officer that he could do all this 'because with God all things are possible'.¹⁹¹

Ideas of unreality

For other patients, feelings of unreality were expressed in which the 'outside world' was changed; that time, objects, bodies and selves had changed, so that their world was no longer recognisable. Ideas of unreality, wrote Henderson and Gillespie, 'are probably psychologically related to nihilistic delusions, but they are not usually delusional, the patient recognising their abnormality, and complaining of the distress which they occasion'.¹⁹² Mary White, admitted 1926 was quoted as having stated that things were going on endlessly: that time "seems so long, endless". Everything, she related, was changed, 'nothing is the same as it used to be'. Her body was 'all different', her 'husband is not her husband' but rather the 'devil who has a face like her husband. The trees she saw outside the hospital were not the same, the food 'is like food but not food', 'her bed is a bed and not a bed' and the water has 'worms and snakes in it'.¹⁹³

Sensorium, mental grasp and capacity

To complete the mental examination, Gartnavel's medical officers could test some of the more easily observable factors, such as the patient's 'Orientation', 'Memory', 'Retention', 'Appreciation', 'School and General Knowledge', 'General Intelligence' and 'Insight and Judgment'. In an era when experimental psychologists were developing a more quantitative approach to psychological testing, the aim of these tests was to establish the extent to which there may be any 'temporary or permanent mental disorganisation'.¹⁹⁴ Many of these tests were aimed specifically to elucidate the presence of organic conditions, especially those associated with syphilitic infection or 'senile cerebral degeneration',

¹⁹⁰ Case no 595 GB812 HB13/5/186/70 NHSGGCA.

¹⁹¹ Case no 654 GB 812 HB13/5/187/54 NHSGGCA.

¹⁹² Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 91.

¹⁹³ Case no 450 GB812 HB13/5/184/47 NHSGGCA.

¹⁹⁴ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 78-81.

which produced defects of memory, disorientation and coordination. In Henderson and Gillespie's *Text-Book* and Kirby's *Guide*, these examinations were heavily based upon the *Handbook of Mental Examination Methods* published by Shepherd Ivory Franz, Psychologist to St. Elizabeth's Hospital, Washington D.C.¹⁹⁵ Both of the textbooks offered condensed versions of Franz's extended publication, and in Gartnavel's case note records it becomes evident that practitioners relied upon Franz's extended version for guidance when faced with more complex conditions necessitating specialized examination methods. What also becomes clear when analysing Gartnavel's case note records is that the application of such tests was most often a highly individualised process, tailored to the specific abilities of the patient. As Franz wrote, 'it must not be assumed that each and every test may or must be applied to each and every patient who is examined'. Many alternative tests were given for the examination of the same mental processes, as Franz found that not 'one method [could] ... be used with advantage with all kinds of patients'. Likewise when judging patients' reactions to the tests, Franz established that 'tests be adapted to the individual and that the estimation of abnormality be based not upon the ability to perform certain definite required reactions, but upon the actual reactions of the individual'.¹⁹⁶

For all such tests, it was considered important to record the time taken by patients as they attempted to complete the tasks, 'so that comparisons can be made later'. If there were any delays, errors or a slowness of response, patients were asked to explain why this should be so. Medical officers especially wanted to ascertain the degree to which a patient's inability to perform a task was due to psychological or organic factors, and so they were taught to discern if there was evidence for feelings of 'mental insufficiency', to gauge whether the patient was deliberately uncooperative, and to ascertain whether there was merely temporary or permanent defects of the patient's thinking capacities.¹⁹⁷ With such emphasis placed upon the patient's precise response to the mental tests, Gartnavel's clinical clerks recorded the dialogues that passed between patient and practitioner with a high degree of accuracy. The following analysis of Gartnavel's case note records therefore demonstrates how Franz's overarching principles were applied and modified within certain clinical encounters.¹⁹⁸

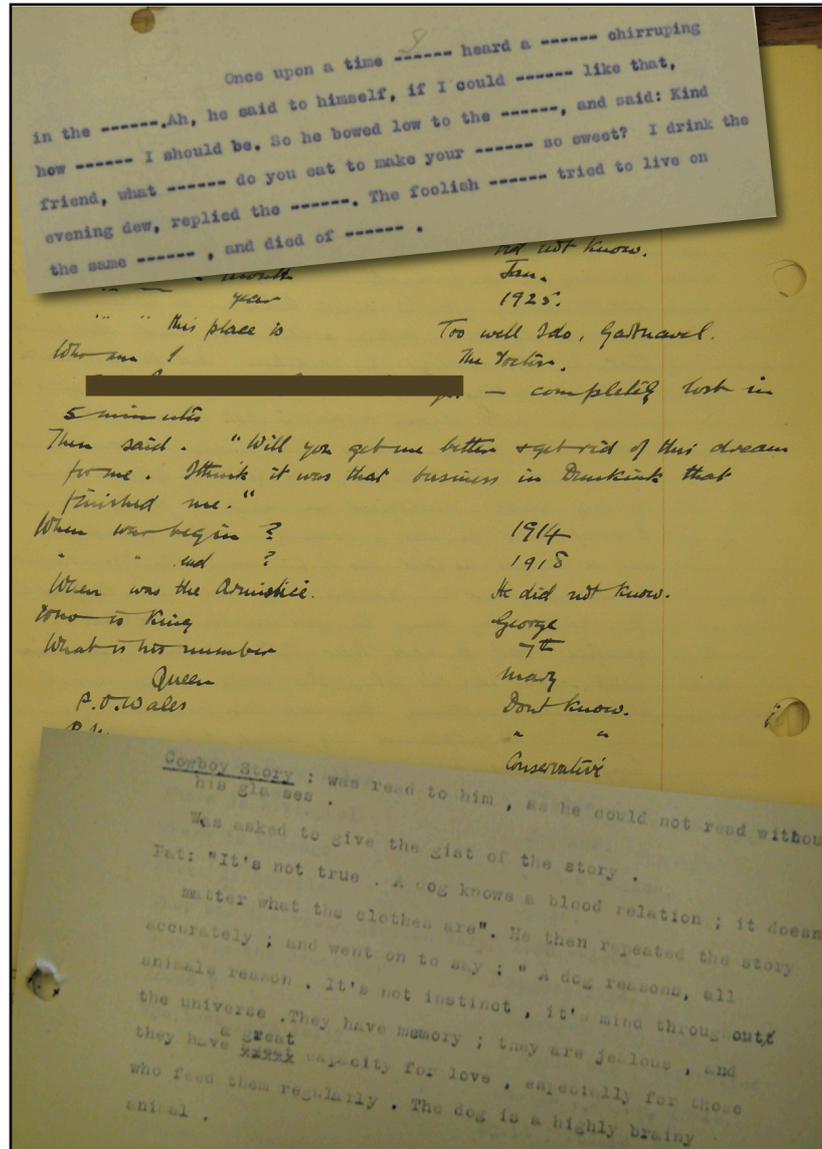
¹⁹⁵ Shepherd Ivory Franz *Handbook of Mental Examination Methods* (New York: The Macmillan Company, 1919).

¹⁹⁶ Franz *Handbook of Mental Examination Methods* pp. 13-14.

¹⁹⁷ Kirby *Guides for History Taking* pp. 72-73.

¹⁹⁸ *Ibid* p. 69.

Figure 13, sensorium, mental grasp and capacity. Samples of mental examination tests examining such aspects of mentation as 'Orientation' 'Memory' 'Retention' 'Appreciation' 'School and General Knowledge' 'General Intelligence' 'Insight and Judgment' taken from Case no 302 GB812 HB13/5/182/12, Case no 595 GB812 HB13/5/186/70, Case no 123 GB812 HB13/5/179/23 NHSGGCA



Orientation

Most often medical officers began by testing the patient's orientation by asking questions such as "What day is it?", "What time of day is it?", "What month is it?", "What place is this?", "What kind of place?", "Who am I?" and "What is my occupation?" (see figure 13).¹⁹⁹ For one patient whose 'orientation for time' was considered 'fair', but whose orientation for 'place and person' was considered 'bad', the case note record read as follows:

What time is it? 12o'clock (c.) day. Sunday. Date. No I don't know it. March February. Beginning year 1923. Place? Don't know I think its about the Clyde but I've never been outside to see. Name of this place? No I don't know. Kind of place? I can't say. I've heard it called St. Helens Hospital (probably confabulation. Did show confabulation last night when he said Dr Mackinon he had met years ago.) Could not identity the M.O. said he had never seen M.O. before here but that he had met him somewhere.²⁰⁰

Memory

Next was the test for memory. This, advised Henderson and Gillespie should be done by asking the patient to give a chronological account of their life, taking into account such important events as their 'place and date of birth', their 'age on going to and leaving school', whether they were married and when the marriage took place. Enquiries into the patient's memory for recent events were obtained by asking such questions as 'When did you come here', 'Where from' and 'With whom'. So, for example, one patient was asked his date of birth, the name of school he attended and his previous occupation, all of which he answered correctly, but when asked to name his own doctor he failed to recall his name. It was noted in his case note record that 'There seemed to be a great lack of memory for recent events'. When asking him to detail what he had for dinner the previous evening he could not remember, but it was nonetheless noted that 'when it is suggested that he had a certain thing he agrees willingly'. The assumption was made that the patient failed to answer 'not because he does not know', but because he 'cannot be induced to set his mind to think on the particular subject in question'. This, among other examples, demonstrates the principles specified by Franz that patients were to be judged not merely by their 'ability

¹⁹⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 78.

²⁰⁰ Case no 123 GB812 HB13/5/179/23 NHSGGCA.

to perform certain definite required reactions’, but also upon the ‘actual reactions of the individual’ towards the particular mode of examination.²⁰¹

Retention and immediate recall

Examination of the patient’s ‘Immediate Memory’, otherwise described as the ‘power of retention’, was most often enquired about next, with the patient being asked to remember a given street address, a person’s name, a colour and an object such as a cabbage, a table or a house. After set intervals of time such as five minutes, an hour or several days, the patient was asked to repeat facts which they were requested to remember. This process is demonstrated in the excerpt quoted below, which moved from the analysis of remote to recent and then immediate events. It was summarised that the patient’s memories for remote events was good, but that their recent and immediate memories were ‘fair in patches’ but ‘generally poor’:

Memory ...

When born? 1877 ... where (puzzled look) either Edinburgh or Leith. School went to one at Leith. forget the name of it. Left at what age? Can’t say. Occupation? Clerk all the time ... When in here? I think last Thursday. From where? Western Infirmary. At any place after Western before coming here? No. was sent here directly: ... no. I was at a place across the street. I think its connected with this place. Breakfast porridge. Bread tea. That’s all.

380 Broad St

Pink

Cabbage ...

after 5 minutes given as 350 Broad street. Pink. + I forget the other thing.²⁰²

Various other tests were conducted at this point in the examination to estimate the strength of the patient’s immediate memory and recall. ‘The simplest test for memory span’, wrote Franz, was to present the patient with a series of individual numbers and have them reproduce these numbers immediately after they had been given. ‘It is usual’ proposed Franz, ‘to perform these tests in two different ways, first, so that the impressions are received through the ear, and secondly, through the eye’.²⁰³ Hence patients were verbally given a series of numbers that gradually increased in length, which they were then asked to immediately repeat.

²⁰¹ Franz *Handbook of Mental Examination Methods* pp. 13-14.

²⁰² Case no 123 GB812 HB13/5/179/23 NHSGGCA.

²⁰³ Franz *Handbook of Mental Examination Methods* p. 102.

4851	c
7243	72, 43 (c)
659152	659142 (c)
84329	84329 (c)
16254	16254 (c)
791580	791580 (c)
263812	263812 (c)
5769426	5769426 (c)
8103715	8103715
62549341	I've lost that, doctor, then gave it correct.
24715469	24715469
863425018	<u>862435418</u> . Its not correct ²⁰⁴

Another of Franz's tests, especially emphasised by Henderson and Gillespie, was the test of 'word-pairs' which consisted of the patient being read five or ten word-pairs, such as 'Head – hair', 'Room – hall', 'Chair – table', 'Grass – tree' and 'White – red'.²⁰⁵ After this was done, the 'stimulus word' was repeated and the patient was asked to supply the corresponding word. In the case of Jane Brown admitted in 1926 it was recorded that: 'Patient is given word pairs and column A. is then re-read to [patient]. [Patient] attempts to recall column B':

A.	B.	
Bread.	Butter	Butter
Copper	Penny	I haven't got – that
Bridge	Water	No
Sea	Green	Green
Head	Hair	Cap
Cap	Cloth	No
Ship	Plates	I can't take so many in
Brick	Straw	Wall
Green	Blue	No I can't do there's too much
Glass	Cork	No I can't
Pen	Paper	“ ”
Horse	Harness	“ ” ²⁰⁶

A further test used to gauge the strength of the patient's retention and immediate recall of information was 'Marie's three-paper test'. This test, originally conceived by the nineteenth- century psychiatrist Pierre Marie, consisted of the patient being shown three

²⁰⁴ Case no 281 GB812 HB13/5/181/49 NHSGGCA.

²⁰⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 79.

²⁰⁶ Case no 497 GB 812 HB13/5/185/32 NHSGGCA.

pieces of paper, each of a different size, and being given instructions as how to dispose of each: ‘e.g., throw the largest piece out of the window, put the middle size piece in your pocket and give me the smallest piece’.²⁰⁷ Duncan Willet, admitted in 1927, was instructed to fold and also to tear certain pieces of paper, but it was found a difficult command to follow:

The patient looked vaguely interested, took the three pieces of paper, said “Small piece as it is?” : then “Was the large piece in half? Not in three?”; then “Was it the large piece?” and again “Was it the large piece” [M.O. “Middle-sized piece”]. He tore the middle sized piece, but nearly tore the large piece as well, forgot to crumple up the paper altogether, and he was going on to tear up the other pieces.²⁰⁸

Speech and aphasia

For patients who evidenced a degree of disturbance in their ability either to express or to interpret the communications of others, tests into ‘speech and aphasia’ were carried out.²⁰⁹ Aphasia, defined by Franz, either as the loss of the ability of give expression to one’s ideas, either vocally, by writing, or by other means, and/or the loss of the ability to comprehend written or spoken language, or other communicatory gestures.²¹⁰ The inability of the above-quoted patient to carry out the three-paper test may have been due to defects of memory or concentration, but may likewise have been due to an inability either to understand the medical officer or to express their understanding through various motor actions; and therefore an array of tests was conducted to discern the nature of sensory or motor disturbances. Tests ranged from those which asked the patient to read aloud printed and written words, or to write their name, the date or an address, to those which asked the patient to perform various commands such as putting their hand on their forehead, closing their eyes or sticking out their tongue. For instance:

Simple Commands. (vocal)

Q. Put out your hand (A) Said “ [indecipherable]”, looked uncomprehendingly at M.O., did nothing.

Q Put out your hand.

(A) [Indignantly] “Where is the hound: Relapsed into murmurings.

Q. Put out your hand? (A) Nothing done.

²⁰⁷ Kirby *Guides for History Taking* p. 71.

²⁰⁸ Case no 612 GB812 HB13/5/187/12 NHSGGCA.

²⁰⁹ Franz *Handbook of Mental Examination Methods* p. 66.

²¹⁰ *Ibid* p. 65.

Q. Rgt ; 4 times (A) Looked at M.O., did nothing but continued looking for a moment.

Q. Put out your tongue (A) [pause] “Its out”.

Q. Put out your tongue; Rpt 2^{cc} (A) Oh for k- a little before I’ll come [indecipherable]

Q. Shut your eyes. (A) And what’s that for.

Q. Rpt (A) And miss you walkin’ ...

Simple Commands (vocal: reinforced.)

Q Put out your hand [M.O. hand held out]

M.O. had held patient by wrist, and she said “I must get some for my hands”: after he said “Put out your hand” patient said with some affect “my hand’s held out”

...

Q “Shake hands? ...

A “Already (surprised) – is that the way you do?” Patient put hand out gradually against M.O.s held hand, but did not attempt to grip it...

Q Pause for suitable moment, then “Put out your tongue”, M.O. put out his

A “Oh, no, - we all do that.

Q. Proceeded as before. “Put out your tongue”.

A. ... “I don’t think he’ll put out his _ stopped, seemingly on formation of word “tongue”.

Q. As before “Put out your tongue”.

A No response, patient looked away.

[An excited patient started shouting outside the door and then at the window – patient took almost no notice] ... repetition of question seemed to have little definite influence on the response.²¹¹

Attention, apprehension and perception

Apperception tests followed on from the analysis of memory, testing the ability of the patient to ‘assimilate and comprehend impressions’. Henderson and Gillespie’s *Text-Book*, which was aimed for students as well as qualified practitioners, somewhat amalgamated Franz’s more extensive research upon ‘Attention, Apprehension and Perception’ into a shortened, more introductory series of tests compiled under the heading ‘apperception’. Within the case note records, though, it is evident that Gartnavel’s medical officers and clinical clerks were influenced by more specialised studies of mental testing, as interspersed between the formulaic order of tests laid out by Henderson and Gillespie, were the more in depth studies elaborated upon by Franz.

²¹¹ Case no 468 GB812 HB13/5/185/3 NHSGGCA.

These tests, wrote Franz, initially functioned to investigate both the ‘memory’ and the ability of the patient to sustain their ‘attention’ upon certain tasks. Franz defined attention as the ‘focusing of the consciousness on some particular situation or thing’ and the following tests were designed to assess the ability of patients to apply their attention to particular instructions, images, numbers or words. Franz further wrote that ‘the ability to take in stimuli also depends on the ability to retain and reproduce the stimuli’, so the patient’s memory was likewise brought under further examination.²¹² Simple tests such as asking the patient to tap on the table with a pencil or clap their hands every time a stimulus word was mentioned were designed to ascertain whether the patient’s attention fluctuated, whether there were times when it increased in speed and accuracy, and when periods of ‘fatigue’ set in. A gradual lessening of the patient’s attentive abilities as the examination progressed was seen to evidence a normal ‘phenomenon due to the “wearing out” of the nervous structures’, but fluctuations in attention which alternated from ‘high and low speeds’ were seen in many cases to indicate certain organic nervous conditions and were therefore of great diagnostic importance.

The strength of attention paid by the patient to such tasks was theorised by Henderson and Gillespie to depend a great deal upon their ‘preoccupation with their own problems’. In certain psychological states, decreased attention was seen to result from a lack of interest or a decided ‘shutting-out’ of the external environment, whilst the inability to attend to the tests in hand, ‘in spite of the wish to do so’, was recognised as often being symptomatic of organic disease.²¹³ For Franz, the way to judge whether the patient paid due attention to the task at hand was to evaluate the ‘motor adjustment’ shown by the patient towards environmental stimuli. Attention was conceived as a state of consciousness which fluctuated in strength, only reaching its highest point of intensity when some special situation or object was vividly presented and focused upon, and it was at these moments that sensations, thoughts and other ‘motor adjustments’ were stimulated.

Apperception

Analysis of attention was intertwined within the following tests, but, as attention, memory and comprehension were amalgamated within Henderson and Gillespie’s *Text-Book*, analysis often focused upon the more complex analysis of apperception. Apperception,

²¹² Franz *Handbook of Mental Examination Methods* p. 81.

²¹³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 96.

otherwise termed perception, was defined as the accumulated outcome of these mental process. ‘Perception or apperception’, wrote Franz, occurs as the individual focuses not only their attention and corresponding memories to certain tasks, words or objects, but takes in a ‘presented situation’ and ‘make[s] it part of one’s mind’. ‘A sensation is an abstraction’, conjectured Franz: ‘as adults we are never conscious of sensations in themselves; we are conscious only of perceptions or of apperceptions’. Franz defines sensations as the primary affects of environmental stimuli, and expresses these sensations as always existing in the conscious mind in combination with an individual’s past memories, so that sensations are always laden with meaning:

It is this giving of meaning to the sensation that we call perception or apperception, and this, as has been said, is brought about by the association or combination of the present sensory impulses with the relics of former experiences.²¹⁴

One test (see figure 13), the records of which have been found in several patient cases, was to give the patient a short story to read, and then to ask them to ‘give the gist of what he has read’. One such story taken from Franz’s examination methods read as follows:

A cowboy from Arizona went to San Francisco with his dog, which he left at a friend’s while he purchased a new suit of clothes. Dressed finely, he went back to the dog, whistled to him, called him by name, and patted him. But the dog would have nothing to do with him in his new hat and coat, but gave a mournful howl. Coaxing was of no effect, so the cowboy went away and donned his old garments, whereon the dog immediately showed his wild joy on seeing his master as he thought he ought to be.²¹⁵

It was recorded that, after being read the cowboy story, one patient replied:

Pat: “It’s not true. A dog knows a blood relation; it doesn’t matter what the clothes are”. He then repeated the story accurately; and went on to say: “ A dog reasons, all animals reason. It’s not instinct, it’s mind throughout the universe. They have memory; they are jealous, and they have a great capacity for love, especially for those who feed them regularly. The dog is a highly brainy animal.”²¹⁶

Other patients were asked to read the ‘Shark Story’ and were again asked to give an approximate account of the story. For one patient, it was recorded that he read the story

²¹⁴ Franz *Handbook of Mental Examination Methods* p. 74.

²¹⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 79.

²¹⁶ Case no 595 GB812 HB13/5/186/70 NHSGGCA.

well, but that he was ‘very anxious’ to point out how ‘he would have done much better a few weeks ago – that now he feels so stupid’.²¹⁷ ‘The feeling of the patient’, advised Franz, ‘in regard to his memory ability is known as an unsafe guide or indication of the real condition’, and therefore this patient’s assertion that his memory failed him only in the last fortnight may not have been taken at face value. Nonetheless, Franz wrote that the patient’s own ‘feelings and supposed deficiencies in memory must be considered’. At times, Franz wrote that these aspects may be ‘almost as instructive as the real memory weaknesses’, and therefore patients’ own comprehension of their memory states could be symptomatic of either memory loss, or false recollections.²¹⁸

One final example of the test for apperception was the Ebbinghaus test (see figure 13). Used to examine the ‘thinking capacity and the power of attention’, the foci of these tests were regarded by Henderson and Gillespie as especially important topics for analysis under the generalised heading of ‘Apperception’. These tests were closely aligned with those which judged the patient’s ability to comprehend environmental stimuli, but they tested further the patient’s ability to sustain their attention and actively transform the appreciation of stimuli presented in an incomplete form into concepts with meaning and understanding. In the following test the patient, wrote Franz, ‘is presented with a sheet of paper on which one of the following stories has been printed and in which words ... have been omitted and replaced by blank lines’. After the patient was instructed to read the story, they were asked to complete the story using words most appropriate to the coherent telling of a tale. If the patient’s use of words made the paragraph ‘sensible and consistent’, then their answer was considered correct, but if the paragraph as a whole was ‘not sensible’, it was considered a poor attempt:

“Once upon a time _____ heard a _____ chirruping in the _____. ‘Ah’ he said to himself, ‘if I could _____ like that, how _____ I should be.’ So he bowed low to the _____, and said, ‘Kind friend, what _____ do you eat to make your _____ so sweet?’ ‘I drink the evening dew’, replied the _____. The foolish _____ tried to live on the same _____, and died of _____.”

The above figure 13 displays examples of this test, showing how a number of patients were wholly unable to fix their concentration on the task. For others, varying degrees of success were attained, but, as this test was usually carried out on patients already showing a degree

²¹⁷ Case no 128 GB812 HB13/5/179/28 NHSGGCA.

²¹⁸ Franz *Handbook of Mental Examination Methods* p. 92.

of mental disorder with regard to their memory and retentive powers, for most they display the inability successfully to complete the story. One patient was recorded as having written in the blanks:

“Once upon a time *we* heard a *clear* chirruping in the *woods*. ‘Ah” he said to himself, ‘if I could *whistle* like that, how *very happy* I should be.’ So he bowed low to the *lady*, and said, ‘Kind friend, what *sweet thing* do you eat to make your _____ so sweet?’ ‘I drink the evening dew’, replied the _____. The foolish _____ tried to live on the same _____, and died of _____.”

This, it was recorded, was ‘very badly done’, and after ten or so minutes of ‘half hearted attempts’ she gave up trying. ‘She was unable to give hr [sic] mind to the task and constantly looked about her’. ‘Suddenly’, it was recorded, she said “No, Doctor, you see that’s not meant for me”, after which she could give no explanation as to the meaning of this statement. The medical officer then attempted to move on to an analysis of her ‘School and General Knowledge’, but as this point the patient was observed to show ‘signs of fatigue’ and this line of questioning came to a close.²¹⁹

School and general knowledge

For those patients who did undertake this part of the examination, questioning turned to facts of general knowledge such as simple arithmetic, history and geography. For example, patients were often first asked to undertake math-based questions, one of which was the repeated subtraction of 7 from 100 which, in the following case, was answered with the following series of numbers:

100 -7. 93. 88. 81. 74. 67. 60. 53. 46. 39. 32. 25. 18. 11. 4.²²⁰

These general knowledge questions were made with ‘due regard’ to the patient’s educational level and the ‘general experiences of the individual’, and sufficed to enable the medical officer to judge if the patient was ‘illiterate, mentally deficient or markedly deteriorated’.²²¹ These varying states of intellectual development and deterioration were to be assessed throughout the mental examination, but, as the examination came to a close, patients were asked more pointed questions to gauge more accurately their grasp of general

²¹⁹ Case no 655 GB812 HB13/5/187/55 NHSGGCA.

²²⁰ Case no 123 GB812 HB13/5/179/23 NHSGGCA.

²²¹ Kirby *Guides for History Taking* p. 74.

knowledge. Case records therefore report that patients were asked questions such as the following, paired with a variance of patient responses:²²²

Who is the King?	George
Who is the Prime minister	I can't remember
What Government is in power?	I can't tell you
Who is the Chancellor of the Exchequer	I can't do any more. I feel awfully tired.
Who is Mr Asquith? ²²³	

Another patient, Richard Govan was confronted with questions regarding geography and literature, to which he responded:

Time between London and Edinburgh?	7 1/2 to 8 hours.
Name 5 large towns in G.B.?	Aberdeen, Dundee, Glasgow, Edinburgh and London.
3 Long rivers?	Mississippi, Hudson, and Thames.
Who wrote Hamlet?	Shakespeare.
Canterbury Tales?	Chaucer.
Who wrote Pickwick?	Dickens.

Then the patient stood up, and said "this is very interesting" in a delightedly enthusiastic tone and then he gave the speech from the court Scene in *Pickwick Papers*, where the prosecuting lawyers speaks for Mrs Bardell. It was probably correct; was delivered with effect, and only with an occasional stop to go over a few words to bring certain bits to mind. He stated that he learned this as a boy when he was 15, at school ... he won a first prize against 60 pupils – for elocution.²²⁴

Such a response furnished evidence of the patient's general knowledge, but also inferred the symptomatic nature of his stream of thought, characterised by a great deal of 'spontaneity' and 'unnecessary detail'.²²⁵ Likewise in the above quoted case, the patient's inability to answer questions regarding general knowledge may have pointed towards defects in memory, appreciation and retention, as well as fatigue or resistance, and therefore repeated examinations were sometimes undertaken to ascertain more clearly the symptom picture.

²²² The meaning of 'mentally deficient' denoted the presence of intellectual or emotional disabilities, which were brought about by congenital defects, or by 'faulty habits of training' that stemmed from the patient's environment. Deterioration differed from defect, as this denoted a loss, or a falling away of a patient's general intellectual powers. Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 382.

²²³ Case no 497 GB 812 HB13/5/185/32 NHSGGCA.

²²⁴ Case no 595 GB812 HB13/5/186/70 NHSGGCA.

²²⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 85.

General intelligence

When ascertaining the general intelligence of the patient, Franz wrote that the practitioner was dealing with some of the more complex mental processes requiring comparison, judgement and intuition.²²⁶ When endeavouring to clarify the patient's general intelligence, Henderson and Gillespie advised that it was sometimes most effective 'to ask more abstract questions, and ask what is implied by it'. Allowing the patient to express more fully, and with a greater degree of freedom, their response, Gartnavel's medical officers were able to judge the patient's 'ability of discrimination, comparison and description'.²²⁷

For instance, there was the Ziehen Test, which asked patients to differentiate the meaning of one word from another, such as 'a lie and a mistake', 'idleness and laziness' or 'cloud and mist'. One patient, when first asked the difference between 'idleness and laziness', replied:

'Laziness is Inherent. Idleness may be through no fault of ones own.
Difference between Poverty and misery?
Poverty may not mean unhappiness but misery does. Usually they mean the same thing.'²²⁸

Another line of questioning suggested by Kirby was to ascertain the patient's ability to correlate facts with experience, otherwise termed by Franz as 'Logical Tests'. '[M]ost normal people of average intelligence' supposed Franz, 'are able to decide that a simple proposition is correct or incorrect'. Patients were given simple logical propositions, which they were asked to agree or disagree if the underlying premise was correct. One patient, presented with the following statements, was considered as showing a poor grasp of logic:

Thinking

He was asked to state whether the conclusion arrived at in the following propositions is correct or not:

He shows a definite defect in his clarity of thought.

1 All roses are beautiful; lilies are not roses; therefore lilies are not beautiful.

Logically it is correct.

²²⁶ Franz *Handbook of Mental Examination Methods* p. 142.

²²⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 81.

²²⁸ Case notes no 292 GB812 HB13/5/182/2 NHSGGCA.

2 Nothing is better than wisdom; dry bread is better than nothing; therefore dry bread is better than wisdom.

That's right²²⁹

For many patients, general intelligence was gauged by the 'general character' of the patient's response to the former lines of questioning, but when tests for intelligence were performed Kirby warned that 'Great care must be exercised when judging the results' of such tests, most significantly when the patient was in a 'psychotic state'. When it came to intelligence tests, Kirby stated, that 'because of abnormal emotional reactions, lack of effort, inattention, inhibition, negativism, delusional ideas, etc', intelligence tests could prove to be quite misleading.²³⁰ With patients often passing through differing stages of illness, ranging from acute periods to convalescing phases, repeated testing was necessary to obtain a more accurate report of the patient's mental abilities throughout the course of illness.

Insight and judgement

Insight and Judgement.

Do you realise that you have been ill mentally – well I seem to see things + people right enough yet I'm very forgetful. I can't think what's come over me. I seem to be all wrong all together.²³¹

The final test in the mental examination was quite simply to ascertain the degree of insight held by the patient: whether they appreciated the need for treatment and/or the extent to which they felt themselves to be ill. Kirby wrote that the medical officer should enquire whether the patient understood that they had suffered a mental disorder, and to ascertain whether the patient was 'sensitive to errors made, appreciates defects of memory or other failure of capacity'.²³² Enquiries into patients' plans for life after discharge were notably to be investigated, as evidenced in the following excerpt:

He feels sane + clear in mind. "clearer" than ever. He doesn't think he is mentally ill. "I don't believe I shall ever die". He is going to build a ship canal between Glasgow and Edinburgh _ 6 cathedrals in Edinburgh + later a similar number in Glasgow.²³³

²²⁹ Case notes no 292 GB812 HB13/5/182/2 NHSGGCA.

²³⁰ Kirby *Guides for History Taking* p. 75.

²³¹ Case notes no 297 GB812 HB13/5/182/7 NHSGGCA.

²³² Kirby *Guides for History Taking* p. 77.

²³³ Case notes no 595 GB812 HB13/5/186/70 NHSGGCA.

Conclusions: Moving towards the collation of a dynamic case note record

In order to get at the dynamic factors ... it is usually necessary to have repeated interviews and finally to make a careful analysis of the entire material.²³⁴

While the anamnesis and the physical and mental examination made up a firm foundation upon which to build a case history, Gartnavel's medical officers relied upon a process of on going consultation to formulate a case history that held true diagnostic and prognostic significance. The 'staff meeting' was often the next stage in the analysis of a patient, as Gartnavel's medical officers endeavoured to construct a dynamic, clinically rigorous, case note record. Within the next chapter, analysis shows just how the disparate parts of the anamnesis, the physical and mental examination, were drawn together with the staff meeting. With patient cases viewed in terms of the underlying pathology, recognisable symptom pictures were drawn together to form reaction types. I therefore question just how this process of debate and consultation was productive of revised and diagnostically aligned patient identities. Moreover, the role of the patient in shaping and engaging in the staff meeting discussion will be explored.

Before commencing to this next stage, however, it is worth reflecting on the purpose of this chapter. Analysis has so far demonstrated how the case note record was made up of disparate elements, such as the hereditary report, the personality study and tests of memory and attention. It has shown how the individual life histories and bodily ailments of Gartnavel's patient population were investigated as a dynamic whole, so that the patient was primarily examined as a 'human being' rather than a mere diagnostic entity. Nonetheless, the methodological structure of this chapter is purposefully problematic. As stated in the introduction, this chapter functions to highlight the limitations of analysis, which picks and chooses choice excerpts without representing the full case note record. This is not to say that this process, which 'dissects' the case note record, is not essential to our understanding of a records construction. To begin to appreciate and impart meaning to the narratives of patients and medical officers, which are now embedded within case note records, one *must* have a clear understanding of the linguistic, clinical, social, historical and spatial contexts in which they were recorded. But in no way can this chapter, which spans micro and macro scales of analysis, adequately reveal the complex layering of

²³⁴ Kirby *Guides for History Taking* p. 68.

meaning that emerges from a single case note record. It cannot instil the level of empathy, or comprehensibility needed to truly begin to understand how a patient's medical identity was constructed within the case note record. This chapter, like the proceeding chapters on the staff meeting and on patient narratives, dissects significant components of the case note record, interspersing published materials and clinical guides with excerpts taken directly from patient cases. It evidences a breadth of experience; it instils a wide temporal and geographical framework, and it is against such a backdrop that Chapter Seven, an in-depth study of a single case note record, may be understood as an example of a dynamic case note record, integrally aligned to the philosophies of Meyer which study the whole patient, adapting over their lifetime, to changing social and physical environments.

CHAPTER FIVE

DIAGNOSIS AND PROGNOSIS THROUGH THE LENS OF THE STAFF MEETING

Patient was reluctant to come in, saying, “I must not come in. I am all destroyed. Look at the lot of men, I am destroying you, and I am destroying these other gentlemen too”. Asked to sit down, she said “I have destroyed the chair. I am destroying the whole lot of you. I have no clothes or anything else left – you have no idea of how they have all been destroyed.”¹

Several days, sometimes several weeks after arriving at the hospital, each of Gartnavel’s newly admitted patients were encouraged to attend a staff meeting (see fig 14). Escorted by a nurse from their respective wards to the ground floor meeting room, a medical practitioner, sometimes Henderson himself, greeted the patient upon their arrival. Asked to sit down, patients were directed to face the interviewing medical officer, while a gathering of Gartnavel’s resident staff was seated behind the patient. “I usually try to see every person who comes here in this way”, Henderson stated to one patient during a staff meeting in 1925, to “have a talk over things with them.”²

In emulation of the case conferences carried out at the Phipps, the staff meeting was, and still is, a method of examination which began with a medical officer presenting the history of a case to a gathering of the hospital’s medical staff.³ The corresponding patient was then invited into the meeting room, and was interviewed by the presenting medical officer. This interview went on in front of a panel of psychiatrists who, upon the patient’s departure from the interview room, discussed the diagnosis, treatment and future management of the case. Orchestrated in such a way as to emulate the intimacy of a mental examination, while then enabling Gartnavel’s medical officers to present, discuss and debate the individual

¹ Case no 425 GB812 HB13/5/184/22 NHSGGCA.

² Case no 631 GB812 HB12/5/187/31 NHSGGCA.

³ Records show that in the case of Jeanie O’Brian, Henderson informed the patient that before her arrival, Dr Thomson ‘had been telling them something of her history and condition’. The patient, therefore, was aware that the entire board had been informed of the particulars of her case, suggesting Henderson endeavored to leave the patient in no doubt that her case was being discussed by all of Gartnavel’s medical officers. Case no 680 GB812 HB13/5/187/80 NHSGGCA.

case within a conference environment, the staff meeting allowed for the ‘presentation of the facts under the critical eye of all the physicians of the hospital’.⁴

Within the Phipps Psychiatric Clinic, Meyer advised that the staff meeting be carried out three times during the treatment of the patient: once during the first five days after their admittance; once again four to ten weeks after admission; and finally in the days immediately prior to the patient’s discharge.⁵ In 1921, Henderson reported that the staff meeting was carried out three mornings weekly within Gartnavel, with newly admitted patients or ‘cases of especial interest’ being ‘presented and discussed’.⁶ For some of Gartnavel’s patients, their case note records evidence that they attended a staff meeting twice during the course of their treatment. For others, records attest to them having attended only a single staff meeting, but in many cases not one record of the patient’s attendance at a staff meeting exists. It is difficult to ascertain whether the lack of documentary evidence reflects a failure on the part of Gartnavel’s staff consistently to carry out the meeting, or whether this reveals a loss, displacement or purposeful omission of the corresponding records.

Nonetheless, from the 26 staff meeting transcripts retrieved from case note records, a fascinating insight can be gained into this most rare of clinical encounters within Britain during the 1920s. Not only is Henderson one of the first psychiatrists to introduce the staff meeting method of consultation to British mental hospitals, but, as stenographers were employed to record word by word the proceedings of these interviews, surviving transcriptions reveal the raw, largely unmediated, dialogues that passed between patient and practitioners at these events. Before these kinds of recording methods were used in mental hospitals the voices of patients and practitioners were partially recorded by clinical clerks and medical officers. Case notes, annual reports and published case histories quoted choice, often highly abbreviated samples of these dialogues, but it is not until the 1920s that the employment of stenographers within Gartnavel’s staff meetings allow scholars

⁴ Adolf Meyer, excerpt from the ‘Eighteenth Annual Report of the State Commission in Lunacy’, September 30 (1906) 59-66, reprinted in *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) p. 49.

⁵ Meyer wrote that: ‘In order to make the *staff meetings* as helpful as possible ... they should provide for a presentation of the patient and of the data and a thorough examination with five days after admission (the law requiring of the superintendent a personal examination of the condition of the patient within five days after admission). A second presentation of the patient is made with a summary of the facts and a revised diagnosis within about four to ten weeks after admission, and a third presentation is made before discharge’. See Meyer, excerpt from the ‘Eighteenth Annual Report of the State Commission in Lunacy’ p. 49.

⁶ Henderson ‘Report of the Physician-Superintendent for the Year 1921’ p. 20.

such a unique insight into the clinical encounter. Indeed, as John D. Stoeckle and J. Andrew Billings claim, to learn about the exchange that took place between doctors and patients in clinical encounters before the 1940s is difficult. '[B]efore the first recordings of actual interviews (audiotapes of psychiatrists and patients in the 1940s)' they write that 'the complaints of medical patients and the questions of their doctors were hard to reconstruct from the memories of either'.⁷ The staff conference at Gartnavel is therefore one of the rare documentary sources that are the exception to this general statement, preserving dialogues from within clinical encounters pre 1940.

Analysis of the staff meeting therefore begins with the entrance of the patient to the meeting room. Within the first section of this chapter, the investigational techniques and therapeutic strategies used by Gartnavel's medical officers will be discussed, while the active role played by the patient within such clinical encounters will likewise be considered. Once the patient left the staff meeting, medical officers then went on to discuss the diagnostic and prognostic significance of the case, and I therefore investigate the construction and outcome of the staff meeting process. A third section concludes by looking at those cases in which patients were absent, or deprived from communicating within the staff conference, notably concerning those cases which were organic in origin and resulted in physical and/or mental debility.

Interspersing this chapter with excerpts taken from numerous staff meetings conducted across the decade, analysis looks to the construction of this multi-authorial dialogue as the divergent perspectives of Gartnavel's patients and practitioners were brought together within the meeting room. As the ideas expressed by individual medical officers were debated - as differing perspectives were challenged and complementary approaches applied - staff meeting records reveal the unfolding process by which individual cases were transformed into prognostic and diagnostic formulations.

Staff meeting – part one: an experimental stage

As Meyer himself acknowledged, the progression of the first half of the staff meeting was, like any mental examination, so very much dependent upon the 'personalities' of both

⁷ Stoeckle and Billings 'A History of History-taking: The Medical Interview' p. 119.

patient and practitioner ‘that it is hard ... to discuss general indications’.⁸ In many cases the conversation between patient and practitioner replicated, if in a somewhat condensed form, that which was conducted in the initial mental examination. Yet, while the mental examinations had been used to collate a history that not only pertained to the illness, but to the patient’s life generally, the purpose of the staff meeting was more keenly aimed towards the elucidation of a ‘live’ pathology (the unique adaptive failures of the patient under distinct temporal and environmental conditions) and the specification of future therapeutic treatment.⁹

The use of the hospital as a therapeutic space and an experimental stage upon which the patient was required to ‘adapt’ was an integral part of Meyer’s psychobiological approach, and a keen component to Henderson’s dynamic application of his mentor’s teachings. By encouraging patients within staff meetings and mental examinations to speak frankly about their condition, this, theorised Meyer, could prompt patients to display ‘a variety of reactions through performance’ which may ‘characterize’ their mental ‘disturbance’. Under clinical conditions considered by Meyer as constituting a ‘controlled experiment’ of nature, the task of the medical officer was to judge the ‘modifiability and plasticity’ of such reactions, so that the patient may be guided ‘in the direction of ... self-maintenance in health, happiness and efficiency’.¹⁰ At Gartnavel, it is evident that such an approach was emulated, and the staff meeting functioned both as a ‘pathological laboratory’ (in which dysfunction was investigated and tested) and a therapeutic space in which to begin to correct the patient’s dysfunctional behaviors.¹¹ The following pages therefore trace the process by which the vast and sprawling patient histories, which had so far been collated in the anamnesis and initial examinations, began a process of condensation. Reduced to an experimental formulation of essential ‘facts and factors’ which made up the case, the discussion paves the way for a more in depth look at the formation of a pathology, diagnosis and plan of therapy within the corresponding conference proceedings.

⁸ Lamb *Pathologist of the Mind* p. 229. ‘The Phipps environment – the confluence of its physical spaces, hospital routine and social life – served simultaneously as both a “pathology lab” in which dysfunction was investigated and tested, and a medical instrument with which to correct it’. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 69.

⁹ Meyer ‘Pathology’ p. 112.

¹⁰ Henderson and Gillespie *A Text-Book of Psychiatry* p. 537-42. See also Meyer ‘Pathology’ pp. 114, 116.

¹¹ Meyer ‘Pathology’ p. 112. See also Lamb *Pathologist of the Mind* p. 229.

Stories

Staff Meeting ... March, 1926 – Dr. Thompson.

On entering, patient looked across the room and said “my father and sisters – two of them – are over there just now”.

Q. What are they doing?

A. “Oh, they are seeing what they will take – the best thing there is in this place – a book. They have books at home, but they want to get back earlier. I don’t like the job – not the finish”.

Q. What will the finish be?

A. “I don’t know”...

Q. “Is there any money in it”.

A. “Oh, no, there is no money in it?”

Q. They are just doing it for the love of the thing ...?

A. That is one young lady who has done that”. (showing her skirt, which was rather badly mud-stained, as if she had fallen). “She was going into a little boat, and little boat, and she was standing out on the landing ...” (Dr Henderson remarked on the untidy appearance of the skirt, and assured the patient that it would be brushed, and cleaned up).¹²

As within all mental examinations, the efficacy of the dynamic approach depended a great deal upon the patient’s willingness to co-operate throughout the staff meeting and for a great many patients, the setting of this event must have in itself been a significant factor in shaking their confidence. Speaking in the presence of not one but several members of staff, this loss of intimacy between patient and practitioner was one of many obstacles to be overcome. For instance, in a staff meeting of 1924 it was recorded that Miss Mary Smith was ‘very agitated, and very averse to coming into the room’. Asked by Henderson “What makes you so frightened”, Miss Smith failed to respond, but rather was observed as being ‘very anxious that the nurse who accompanied her, and Dr. Henderson and Dr. Thomson, should be seated, while she herself insisted on standing throughout the interview’.¹³ Another patient, when asked how he was feeling stated he had great difficulty in expressing his feelings within the staff meeting: “I don’t seem to be able just – in here – to know exactly how I feel”. To this Henderson responded ‘You mean your surroundings are so unnatural?’. “No” responded the patient, rather he pointed out that to understand his feeling he would have to experience them in the ‘same situation’ he was in before being admitted to Gartnavel; a poignant remark when considering the philosophies of dynamic

¹² Case no 468 GB812 HB13/5/185/3 NHSGGCA.

¹³ Case notes no 439 GB812 HB13/5/184/36 NHSGGCA.

psychiatry which placed such weight upon the environmental components of mental illness.¹⁴

In another staff meeting transcript we hear how the presence of staff members could alter the tone and content of a patient's narrative. Early on in the staff meeting of Mrs Mary Crawley, she soon began to criticise the hospital, complaining: "I have not seen a paper for ten days". "I am just kept like any common prisoner. I am very angry. (laughing). Wait till I get out!" The board of medical officers, who were sat behind her, had gone unnoticed until this point, when she turned round in her chair and said: "Excuse me, gentlemen, I did not know you were sitting there or I would have been a little bit more cautious."¹⁵ Another patient, James Conry, stated that he could not presently answer Henderson's line of questioning, and 'admitted that he could probably talk more freely to one of the doctors alone than to the group'.¹⁶ Indeed, feeling as though one were up for exhibition was voiced by several other patients, with Mrs Margaret Lyle announcing to the presenting medical officer: "The doctor ... is laughing at me. It is terrible for me to be put up to exhibition".¹⁷

In order to establish confidence, Henderson and Meyer both advised that 'the patient ... be treated absolutely on an equal footing with the physician'. Delusional statements, wrote Meyer, 'must be accepted as one would accept the religious convictions of a person of a different denomination', while remarks made to other practitioners 'must show the same consideration; no pressure must be used'.¹⁸ Moreover, 'in order not to disturb [the patient's] sense of safety or make [them] suspicious that confidences are being betrayed', the physician, advised Meyer, should 'as far as possible' only engage on topics of conversation that have been 'worked out and discussed conjointly with the patient'.¹⁹ In doing so, it is to be surmised that the staff meeting replicated the most fundamental of conditions necessitated for a confidential examination: and by way of demonstration, the above quoted transcript demonstrates the fulfilment of such essential criteria. For, rather than the medical officer's narrative run counter to the delusional beliefs, or 'rigidly conceived premises', held by the patient, the practitioner engaged, and indeed endorsed, the phenomenological reality of the patient's own experiences. Meyer advised that,

¹⁴ Case notes no 269 GB812 HB13/5/181/38 NHSGGCA.

¹⁵ Case no 617 GB812 HB13/5/187/17 NHSGGCA.

¹⁶ Case notes no 128 GB812 HB13/5/179/28 NHSGGCA.

¹⁷ Case no 491 GB812 HB13/5/185/26 NHSGGCA.

¹⁸ Meyer 'Outlines of Examinations' p. 240.

¹⁹ Meyer 'Therapy' p. 157. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68. See also Meyer 'Pathology' p. 112.

through a process of compromise, ideas pertaining to the common reality (as shared by patient and practitioner) should gradually be introduced to the conversation.²⁰ The soiled skirt, for instance, was a point of reference that seems to have been used to draw the patient away from her delusional thoughts, and to point her towards a clearer appreciation of her surroundings.

Once an adequate level of trust was established between patient and practitioner, one of the first steps taken to understanding the pathology of the patient's dysfunctional behaviors was to develop a 'sensitivity to the "stories", [which] the patient may just chance tell'. 'It is obvious', remarked Meyer, that the 'sensitization of the physician' towards the specialist knowledge and individualistic perspective of the patient was of 'great importance'.²¹ Indeed:

... the material of human feelings and thought has such individual concreteness that we cannot often use fixed technical hypotheses and terms, but have to be able to grasp and work with the concrete system of meanings offered by the patient.²²

For Meyer, it was essential that the practitioner was 'always using the patient's facts –*and his own language* – as the basis of any help and advice and further elucidation'.²³ It was the patient's own 'conception' which was 'the field to be plowed and cultivated under the guidance of the physician's fuller knowledge', and at Gartnavel it is evident that Henderson and his medical officers emulated this approach within staff meetings.²⁴ Gartnavel's medical officers duly often studded their questions with words and phrases taken directly from the narrative of the patient. By encouraging patients to elucidate further the meaning of distinct words and phrases that seemed particularly pertinent to the case, medical officers endeavoured to comprehend a patient's own, sometimes unique usage of language. The following dialogue shows Henderson mirroring the linguistic stylistics of his patient as he broached a topic of considerable importance to the patient by stating:

Dr. Henderson. You have spoken about your spine shifting. Do you believe that your spine is –

²⁰ Meyer 'Therapy' p. 175.

²¹ Meyer 'Pathology' p. 143.

²² Ibid.

²³ Meyer 'Therapy' p. 164.

²⁴ Meyer 'Therapy' pp. 163-64.

Patient. (breaking in) Yes I do. When the change comes on it about knocked me off my mind altogether. I think it was me getting the wind up.- it made my nerves worse. A man who is in proper condition has a proper spine – mine is twisted. It is with me getting the wind up this fortnight.”

Dr. Henderson. What change has come over you by getting the wind up?

Patient. “It has turned the wrong way”.²⁵

During another staff meeting, a young female patient complained that, before her admittance to Gartnavel, a doctor down in Harrogate, whom she described as being “merely a general practitioner”, had made her stay in bed practically all day. She complained: “That wretched man I had there made my mind bleed” to which the medical officer replied:

Doctor. “How did he make your mind bleed? Was he attempting to treat you for a mental condition?”

Patient. “He called himself a psychoanalyst! He may have read a little but I know far more about psychoanalysis than he does ... He seemed to do nothing but flirt with me, so I left him.”²⁶

By contextualising, and therefore further clarifying the meaning of phrases such as having one’s “mind bleed”, “spine twist” or to get the “wind up”, this enabled Gartnavel’s practitioners to establish a shared, common ground of understanding, upon which to begin to construct a plan for therapeutic procedure, and from which to ‘formulate the outlook of the case’.²⁷ Nonetheless, an understanding of the patient’s story was only the first step towards correcting their ‘faulty’ adaptations. As previously mentioned, to begin to correct such maladaptation, Meyer wrote that:²⁸

The psychiatrist – the user of biography – must help the *person himself* transform the faulty and blundering attempt of nature to restore balance ... [and] the capacity for self regulation.²⁹

‘In other fields of medicine’, stated Meyer, ‘the therapeutic situation works with material and technique brought in from the outside; in the psychiatric field we need the cooperation of the patient’s better self’.³⁰ Through conversation, and social interaction with the

²⁵ Case notes no 142 GB812 HB13/5/179/42 NHSGGCA.

²⁶ Case notes no 268 GB812 HB13/5/181/36 NHSGGCA.

²⁷ Meyer ‘Therapy’ pp. 160-61.

²⁸ Meyer ‘Therapy’ p. 160.

²⁹ Ibid p. 158.

³⁰ Meyer ‘Therapy’ p. 157.

physician, the patient was encouraged to act as a ‘collaborator in the treatment endeavour’.

³¹ To instil within the mind of the patient a conscious appreciation of their ill-adapted reactions was an essential component of dynamic therapeutic treatment. Therefore, by carefully judging the capacity of the patient to assimilate information given within successive interviews, the intent of these meetings was to arrive at a final consensus; one that bound patient and practitioners in a unified understanding of the cause of the disorder, the plan of treatment and the intended outcome of hospital treatment.³²

Such aims and ideals, which strike the modern reader as being Foucauldian in their very nature, were clearly upheld at Gartnavel.³³ Henderson and his medical officers often used the staff meeting as an opportunity to impress upon the patient the ‘common consensus’ reality that they were indeed mentally ill, and undergoing hospital treatment.³⁴ During one staff meeting, the patient was asked:

Q. Do you understand where you are?

A. “I understand I am in a room”. (Patient had answered the previous questions in a low, rather monotonous voice, and at this point her voice became lower).

Q. Do you know what place it is?

A. “Yes. I forget – Gartnavel”.

Q. Do you know what kind of place it is?

A. “It is a Home for people who are mentally defective”.

It was explained to her that this was true in a sense, that the place was Glasgow Royal Mental Hospital, that people who were nervously ill came, and others because they were unable to look after themselves. Patient then asked “Why did I come here? And was told that it was because she was mentally ill.”³⁵

For another patient, when informed by Henderson that he was in Gartnavel, he exclaimed “Oh, Gartnavel. I thought you were joking. Is that the name of this place”? The patient, when asked by Henderson *why* he thought he was in Gartnavel, replied, “Well, if it is Gartnavel, it must be a different one from the one I mean.”

Q. What one do you mean?

³¹ Jackson ‘A History of Melancholia and Depression’ p. 455.

³² Meyer ‘Therapy’ pp. 164-65. See also Meyer ‘Pathology’ p. 115.

³³ Foucault argues that the body of the psychiatrists is ‘the first reality the patient must encounter ... This body must impress itself on the patient as reality, or as that through which the reality of every other reality will have to pass’ Michel Foucault *Psychiatric Power, Lectures at the Collège de France, 1973-1974* ed. Jacques Legrange, trans. Graham Burchell (Hampshire: Palgrave Macmillan, 2008) p. 182.

³⁴ Jackson ‘A History of Melancholia and Depression’ p. 455.

³⁵ Case no 134 GB812 HB13/5/179/34 NHSGGCA.

A. It is an asylum, Gartnavel? I don't suppose it is that place?³⁶

The patient's reluctance to appreciate his surroundings, postulated Henderson to the board of medical officers, stemmed 'in part' from the patient's family doctor, who had 'impressed upon [the patient] that he was not in any way mentally ill and had refused to have anything to do with him coming here'.³⁷ In order to combat a patient's false impressions, Henderson and Gillespie advised that the physician should show tact, patience, understanding and sympathy towards the patient, but that 'he' should nonetheless be 'quite frank in stating his position'.³⁸ The patient, intimated Meyer, must be re-educated and helped to 'wean himself [off] ... too set an assignment of layman's causes for the various developments'.³⁹

Within various staff meetings, transcripts show Gartnavel's staff applying this approach, whereby they acquired, and then reinterpreted, the patient's narrative, so as to drive home the importance of realising a positive and constructive outlook. In one staff meeting conducted in 1923, the patient answered in reply to Dr Baird that she found it 'rather difficult to explain' just exactly what was wrong. 'Is it hard for you to control your feelings?', Dr Baird enquired, to which she replied "Oh, yes – and it is getting more difficult". One predominant thought, she stated, which occupied her mind was the feeling that she "must have self-control ... I am controlling myself all the time – I am always thinking about it – I cannot be natural somehow".⁴⁰

To this remark, Henderson took up the chance to impart meaning to her actions, and to advise her as to the reasons behind her faulty adaptations. He told her that she was 'perhaps trying too hard, and not allowing herself to be spontaneous and natural':

He explained to her that this would probably right itself when she was a little older; at present she was very young (19), and at the self-conscious stage, when she was apt to think that people were taking a good deal of notice of her, and yet was angry if they did not do so.⁴¹

³⁶ Case no 123 GB812 HB13/5/179/23 NHSGGCA.

³⁷ Case no 123 GB812 HB13/5/179/23 NHSGGCA.

³⁸ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68.

³⁹ Meyer 'Pathology' p. 117.

⁴⁰ Case notes no 132 GB812 HB13/5/179/32 NHSGGCA.

⁴¹ Ibid.

In other cases the ability of the medical practitioner to educate, or indeed to persuade, the patient to change their understanding and outlook was more sorely tested. At a staff meeting conducted in 1925, the aforementioned Andrew Weir, after having been asked if he understood that he had been ‘very ill’, replied: “I do not; I don’t realise what has been the matter with me. I am down and out, doctor”. To this, the medical officer replied:

Q. I do not think so. I think you take an unnecessarily grave view of your condition. I do not see any reason why you should not get better...

Weir’s own conception of the case, stated the medical officer, was that his condition could be attributed to an excess intake of alcohol. After having worked as a doctor out in the Straits Settlement of Singapore, Weir had developed mental and physical symptoms, and this, Weir rationalised, had occurred due to the office culture of taking gin. This belief, the medical officer stated, was in his opinion a falsity, to which Weir replied:

“Well everybody out East takes it – I mean in the Eastern Tropics; you take it in a way you could not imagine had you not been there; ... You do not know the depression of that moist heat – you have to go out – if you have to go out and do something, something responsible, you take alcohol to steady yourself, you see?”

Weir stuck fast to his statement that alcohol was to blame, but as the medical officer steered the conversation towards other events that occurred during his time in Singapore, Weir was gradually encouraged to consider other contributory factors, such as the effect that malaria, dysentery and influenza may have had upon his system.⁴²

While patients’ were guided to look upon their illness from a perspective that was more in line with the medical officer’s own appreciation of the case, patients were likewise directed towards forms of treatment thought valuable by the medical officer. The ‘directing and planning of the case’, summarised Meyer, ‘must utilize the best creative imagination of both physician and patient’.⁴³ By instilling a sense of rationality, hope, and direction that worked in ‘harmony’ with the patient’s own abilities and ‘resources’, staff meetings could work towards a plan of treatment, which, if not made wholly agreeable, was at least palatable to both patient and practitioner.⁴⁴ So, for example, as Jeannie Gove related to Henderson that her home life had proved a great strain, it was recorded that Henderson

⁴² Case no 484 GB812 HB13/5/185/19 NHSGGCA.

⁴³ Meyer ‘Pathology’ p. 118.

⁴⁴ Meyer ‘Pathology’ p. 117.

‘sympathised with the patient, but at the same time pointed out to her that he believed she was capable of doing a great deal better than she had ever done’. What she needed, stated Henderson, was ‘a certain amount of encouragement’, something which the occupational department could provide. To this the patient readily agreed, stating that she must have some ‘incentive’, ‘some goal to take up her attention’.⁴⁵

For other patients, merely the act of talking about their problems within the staff meeting held therapeutic value, as here demonstrates:

(Staff Meeting, ... 1923 – Dr Thompson)

Patient was in a state of great agitation and distress throughout the interview. When asked if she felt any better, she said “No, not really better. The change, and the patients were – Oh – they were noisy when I came first, and it took up my attention and calmed my nerves – something absorbing keeps me quiet”.

Dr. Henderson. “You become worse when you have time to think of your own condition?”

Patient. “Oh, I know. – Oh it is dreadful. Oh, how can I explain. I don’t think anyone has ever lived like me. I will be here long long after you are all dead. I cannot die. I had no way. – my heart just beats on regularly all the time – no noise – nothing as it used to be – nothing affects it ...” Suddenly, breaking off – “Do you want to hear all this”? Dr. Henderson assured her that he did, and she explained that it “soothed her nerves for a short time” to talk about her feelings ...⁴⁶

‘[F]rom the very first contact’, reflected Meyer in the latter decades of his career, ‘we are engaged in treatment’.⁴⁷ As within the first mental examination, the therapeutic effect of telling one’s story to a medically trained ear was recognised by a great many of Gartnavel’s patients, and this process was encouraged within staff meetings. Of course, not every patient was so eager as the patient above to give vent to his or her experiences. Six weeks after the admission of James Conry in 1922, the interviewing medical officer pressed Conry to recognise the value of engaging in a frank discussion. After preliminary enquiries were made within the staff meeting, Conry was asked ‘Do you have morbid thoughts?’, to which he replied:

A. It depends what kind of thoughts...

Q. Do peculiar fancies come to your mind?

⁴⁵ Case notes no 132 GB812 HB13/5/179/32 NHSGGCA.

⁴⁶ Case notes no 130 GB812 HB13/5/179/30 NHSGGCA.

⁴⁷ Meyer ‘Therapy’ p. 162.

A. I cannot remember.

Q. You don't wish to remember.

A. No, it is not that.

Q. You can remember if you wish; if a person wants to remember a thing they can remember it. It is because you don't wish to remember that you do not remember. You wish to forget, to push the thought away. I think it is a great help just to talk out quite frankly...

A. Just at the present moment I do not seem to remember.⁴⁸

Despite Conry at first showing reluctance or, as he stated, an inability to speak his own gloomy thoughts, as the meeting progressed Conry gradually returned to the subject. After a long pause in which neither patient or practitioner spoke, Conry said:

“I cannot just think clearly. You mentioned about having morbid thoughts. I always have a dread of something – whether it is just an incapacity to fight with things or not I don't know. I suppose everybody has a nervous fear?”⁴⁹

Conry's response opened up the subjects of fear and capacity, ones immediately taken up by the medical officer as points for further exploration and elucidation. When a remark voiced by the patient opened up an issue considered most pertinent to the case, Henderson encouraged his medical officers to 'strike the iron when hot', to proceed instantly to educate the patient as to the 'faulty' manner of their adaptation, which may be seen in the medical officer's response.⁵⁰

He was told that practically everyone at one time or another suffered from such fears, particularly during adolescence, and that such was more common than people realised; that as one grew up and developed, these fears as a rule tended to disappear, that one gained more control over oneself, that the imagination was less apt to run away.⁵¹

Henderson then pointed out to Conry that 'he never seemed to have got past this stage of adolescence', and, mirroring the patient's own language, he advised that Conry did, indeed, have 'good capabilities' and that 'there was no reason why he should not be able to pull up and take a better grip of himself'.⁵²

⁴⁸ Case no 128 GB812 HB13/5/179/28 NHSGGCA.

⁴⁹ Ibid.

⁵⁰ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 68. See also Meyer 'Outlines of Examination' p. 240.

⁵¹ Case no 128 GB812 HB13/5/179/28 NHSGGCA.

⁵² Case no 128 GB812 HB13/5/179/28 NHSGGCA.

While Gartnavel's medical officers used the staff meeting to re-educate the patient as to the meaning of their symptoms, the patient's story, as formerly told upon their mental examination, could therefore undergo revision. For instance, at the start of Helen Davidson's interview, she was determined not to reveal anything about her thoughts and beliefs in regards her own spirituality, but finally she revealed to the medical officers the source of her convictions. After having earlier intimated that she was the Virgin Mary, one practitioner asked:

Q. Was there any intimation conveyed to you from any outside source in regard to this? How did it come to you?

A. "I cannot very well explain".

Q. Did you have a feeling as if there was some Heavenly Presence intimating this thing to you?

A. "No".

Q. As if there was a Heavenly Voice that said this thing to you? Did it seem to come from your own inner consciousness, or what? Was it something that seemed to grow up inside you?

A. "No".

Q. How was the information conveyed to you then?

A. "By reading".

Q. By reading what? A. "I cannot very well explain to you".

Q. Was it by reading the Bible, by reading about the Virgin Mary?

A. "No".

Q. Reading about Lourdes, or something else?

A. "No".

Q. What was it that specially seemed to convey that idea to you?

A. "The Bible".⁵³

As tensions between this patient's narrative and that of the psychiatrists saw the patient contradict herself, denying, but then confessing that these ideas sprang from reading the Bible, we witness how the patient's life history was actively being re-negotiated and given meaning within the clinical encounter. We are reminded that we cannot unearth an essential truth about a patient's life history, but rather must explore the active co-construction of the patient's narrative. Readers of the staff meeting record are therefore often confronted not with the meeting of two dichotomous narratives, but with an array of stories, being continually reshaped and revised in the process of the meeting.

⁵³ Case Notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

In cases such as the above, there is a marked distinction between the interview with the patient and the conference following the patient's departure. While a single dialogue flowed between patient and practitioner during the interview, debate and discussion between the board of medical officers was largely reserved for the latter half of the meeting during the consultation process. But for those patients who were less accessible within the interview, the boundaries between these two stages of the meeting were often less distinct. For patients who were reluctant, indifferent, incoherent or inaccessible, the consultation process could often begin while the patient remained seated within the room. Indeed, despite Meyer setting forth an agenda that clearly advised the practitioner to reserve judgement for 'guidance of policy rather than as data to be impressed upon the patient', cases such as the following demonstrate the liminal position occupied by some of the more severely alienated patients who were simultaneously treated as both subject, and object of study.⁵⁴

For example, in the staff meeting of Jeanie McGover, carried out in 1923, it soon became clear that, although the patient could, in some respects, give a clear account of herself, she could not be persuaded to accept that she was mentally ill, nor that she needed hospital treatment, because she maintained that poison was the reason for her illness. Changing the subject, Henderson then stated; "You said King George was here"?, to which the patient replied "Yes, and he is here yet". Without showing any doubt as to the sincerity of the patient's statement, Henderson continued:

- Dr .H. What is he doing here?
P. "He is investigating in this place. We are cousins".
Dr. H. How does it come in?
P. "We are cousins I assure you, through my father and mother".
Dr. H Did you marry a brother of King George's or what?
P. "No, I never married any of them, but we are cousins".
Dr. H. Where does the connection come in?
P. "I cannot go ~~into~~ through it, but we all belong to Paisley".

After the patient expressed a number of such delusions, Henderson turned to address Dr. Thomson, to whom he stated that he found the patient's emotional level to appear 'extraordinarily maintained' and that 'personally he saw little indication of emotional deterioration'. Thomson voiced his misgivings regarding Henderson's opinion, however,

⁵⁴ Meyer 'Therapy' p. 163.

pointing out that the patient had “spoke of being poisoned in the calmest possible manner.” After these men debated over the nature of the case for what may have been a minute or more, the patient broke into their conversation, asking: “But what has all this got to do with bringing me down here?” Debate and analysis of the case was clearly going on in earshot of the patient, and, although she was not included in this part of the consultation, she was clearly engaging, at least at an arguably superficial level, with the contents of the conversation. Henderson and Thomson continued in their discussion: a physical examination, stated Thomson, had not fully been undertaken and ‘the matter should be investigated’. To this remark, the patient once more broke into the medical officer’s discussion. Directly mirroring the language of Thomson, she stated, “I will investigate that you will be punished for keeping me staying here”.⁵⁵

The differential treatment applied to such patients may reflect the more pressing need of Gartnavel’s medical officers to ascertain the non-mental origins of the patient’s disorder. Such was the priority in the following case. Entering the staff meeting, the patient’s narrative at once indicated to the board that she was visually hallucinating. Her conversation, which was at times rational and to the point, drifted in and out of subjects which held little apparent relevance to the medical officer’s line of questioning. Her memory was found to be poor on a number of subjects. Asked if she had any family, she replied:

A. “Seven”

Q. How many sons and daughters?

A. “Five sons, and there are three daughters”.

Q. And how many does that make?

A. “Well, it is not hard to count .. The boys are most, I think. They are more on the list of the boys”...

Q. How many is that?

A. “Twelve is it? And then father tries to do a bit too, but it is not very often”.

At this point Henderson turned to Dr Thomson who was the presenting medical officer. Stating his opinion that the case was “very different from an ordinary arterio-sclerosis”, the patient commented “Yes, that is so”. Thomson replied to Henderson that her case showed a ‘tremendous degeneration at sixty’. “Arterio-sclerosis”, replied Henderson, “is usually – to put it rather vulgarly – such a spotty thing.” Her case, he suggested, was probably “more

⁵⁵ Case notes no 310 GB812 HB13/5/182/20 NHSGGCA.

like a toxic thing, with toxic factors”. “I thought of encephalitis”, replied Thomson, to which the patient again broke in saying “Well, I will have to go and help to make the tea”.

While the patient declared her inclination to leave the meeting in the midst of the medical officer’s debate, she was persuaded to undergo more specialised tests. Classified by Franz as dealing with speech function and association, these tests focused more upon the ability of the patient to understand the practitioner’s line of questioning, rather than the examination having any direct therapeutic value.⁵⁶

Tongue: ----- “it is not so bad, thank you”.

Asked to hold up her right hand, patient did so;

She also, when told, touched her left ear with her right hand.

When asked to hold up three fingers, she at once did so, saying, at the same time, “Are you wanting the best ones”.

(On Dr. Henderson remarking that she had carried out these orders correctly, she said “My mother was a very correct person”).

She did not, however, obey the request to “knock on the table, come back, shake hands, and sit down”, but simply said “And what good would that do? Well, I will have to hurray away for the tea”. This order was repeated, but again without eliciting a response ...

Shown a watch, and asked what it was, patient said, “What day is it? I will need to see. I could not tell you that just all at once”.

Q. Can you not see?

A. “Oh I can see, but it cannot be very smart when it stops that way”.

Q. What time is it?

A. “Well, it does not seem to go very quickly”.⁵⁷

When analysing staff meeting transcripts, the close similarity between the approaches advocated by Meyer and those undertaken by Henderson are starkly apparent. One case that enables, more than any other, the comparison and contrast of these approaches is a staff meeting carried out in 1923. In the summer of that year Meyer crossed the Atlantic and paid a visit to Henderson at Gartnavel. A report, summarising the case of a patient due to be presented by Dr Dawson was made in preparation for Meyer’s arrival, and Meyer took an active role in the ensuing staff meeting. The patient, named Henry Holmes, had previously proved a difficult case for Gartnavel’s medical officers, and likewise became a challenging case for Meyer. The following transcript evidences both Henderson’s and

⁵⁶ Franz ‘Performance of Acts in Accordance with Simple Commands’ in *Handbook of Mental Examination Methods* p. 67.

⁵⁷ Case no 468 GB812 HB13/5/185/3 NHSGGCA.

Meyer's failed attempts to persuade the patient to accept the common consensus that he was indeed ill, and therefore in need of hospital treatment:

Dr. Meyer. "You don't see that evidently you are not quite well"?

Patient. "I am perfectly well".

Dr. Meyer. "On one sense, but perhaps not in another. You are a little liable to get into a confusion. How would you describe it. How were you this morning"?

Patient. "Absolutely well"...

Dr. Meyer. "I should think that the question of insight would be essential? It would be good if it were possible to get him on a basis when he could really talk of the actual experience – because otherwise it is extremely difficult"...

Dr. Henderson. Stated that he had gone over the various episodes with the patient, who had explained them by saying 'I was mentally ill at that time, but I am now better'. And yet he was not any better...

Dr. Meyer. "How would you describe your mood- your feeling:?"

Patient. "I feel a bit confused at times".

Dr. Meyer. ""How are your spirits – your feeling"?"

Patient. "My spirits are all right".... "Perfectly well".

Dr. Meyer. "I do not think you are perfectly well. You do not think so yourself... You would not be here. You would not have any confusion if you were perfectly well. You want to be better, don't you.? And the way to get better is to realise what is wrong, and then get better."⁵⁸

With the patient remaining largely inaccessible, the interspersed consultation within the interview demonstrates how Meyer himself advocated such a procedure in cases such as this one. Like Henderson, Meyer used the environment of the hospital to enforce upon the patient the idea that his residency in a mental hospital proved he was not in a 'perfectly well' state of health. Moreover, as it was impressed upon the patient that the way to recovery was to recognise his illness, and to talk frankly about his feelings. As before, the approaches of the two men once again overlapped within the clinical encounter.

The final stage of such a meeting, proposed Meyer, was usually to agree upon a plan of treatment that the patient could follow out in the days to come.⁵⁹ Henderson regularly finished up the interview by giving a positive and hopeful outlook to the patient, if indeed this was the case, intended to give purpose and lay the groundwork for future work. Of course, such positive reinforcement was not always reciprocated. For one patient, named Donald Robertson, Henderson assured him that all of the doctors present saw no reason

⁵⁸ Case notes no 229 GB812 HB13/5/180/69 NHSGGCA.

⁵⁹ Meyer 'Therapy' p. 162.

why he should not get better, but the patient broke in to say “That blinking place down there will set me right off. There is no one to talk to – everyone is more balmy than another. I am not in a properly controlled state myself, but I am not stone-ginger.”⁶⁰

In cases where the patient was preparing to leave the hospital, either to be discharged or transferred to another hospital, staff meeting transcripts may reveal the parting words that passed between patients and Henderson. In the case of George Armstrong, a voluntary patient who requested his own discharge, Henderson ended the staff meeting by informing his dissatisfied patient that ‘you are going away to-day!’:

... you have been a disappointment to us – we thought we were going to make a success of you ... I think you are your own worst enemy. It is hard for you to take advice, it is hard for you to be guided”. ... This illness has taken a grip of you; your mind at the present time is centered entirely on yourself, and entirely on your own affairs; you cannot possibly think of other people ... of how your illness affects other people, and it does affect them.⁶¹

After this patient took over the direction of his own treatment, we hear Henderson unequivocally stressing the need for the patient’s full cooperation, and his inability to persuade the patient otherwise.

In another transcript, the conversation between Henderson and his patient evidences some of the preparations made jointly by Gartnavel’s staff and the patient’s family members, to ease the patient’s transition. When the patient, Agnes Sneddon, was about to be discharged home, Henderson began her final staff meeting, explaining that he ‘wished to have a short talk with her before she left’. “You know a housekeeper has been engaged”, he enquired, to which Sneddon ‘quickly’ replied “No, I don’t. I know nothing about it”. The stenographer reported that Henderson went on to tell Mrs Sneddon:

[T]hat Mr. Lloyd (one of her trustees) had called on Dr. Henderson a few days ago to make arrangements for her leaving hospital and for her care afterwards.⁶²

⁶⁰ Case notes no 142 GB812 HB13/5/179/42 NHSGGCA. A possible meaning for the term ‘stone ginger’ is that of ‘certainty’ or ‘definite’. Deriving from British slang, his use of the term may signify he considered himself to be ill, but not to the same degree of severity that he saw in other patients.

⁶¹ Case notes no 302 GB812 HB13/5/182/12 NHSGGCA.

⁶² Case notes no 309 GB812 HB13/5/189/19 NHSGGCA.

Henderson went on to state to the patient that “I said I was perfectly satisfied you should be at home so long as I knew there was someone there with you, someone who would help you a bit ... I thought that was the right thing to do”. After the conditions of her discharge were explained, Henderson went on to further advise her as to terms of her six month probation: “if everything goes along all right, and you are happy and have no difficulty during that time, at the end of the six months you should send me a certificate, and to the Board of Control ... from a medical man, saying that you are perfectly all right. You see?” With such reassurances and directions, Henderson asked if she had anything final to say. “No” she replied “except to ask when I am going”.⁶³

Staff meeting – part two: a deliberative arena

Once patients left the interview room, plans for treatment and pathological histories were then more fully discussed as the board debated the diagnostic and prognostic significance of the case. This transition, from the presentation of an individual patient to the discussion of their case, is often heard in the language of the presenting medical officer; often changing from the conversational and inquisitive tone used in dialogue with the patient, to one that was explanatory, that critically engaged with the facts of the case and the opinions of fellow staff members. Gartnavel’s medical officers duly turned from the exploration of the personal and particular, to a wider exploration of a diagnosis or a reaction type.⁶⁴ While the board strove to convert the idiosyncratic features of the case into a diagnostic and prognostic formulation, the following transcript of a staff meeting conducted in 1924 shows that it was upon the basis of comparison with other well-known cases (this time characterised by ‘mechanisms’ of ‘compensation’ and of ‘wish fulfilment’) that the individual case began to be converted from a story of individual experience to a ‘live pathology’ and ‘differential diagnosis’.⁶⁵

Dr. Henderson. “She is very much on her defence... Her sister and she lived together, and the patient was really the dominant one of the two. The sister was a teacher, and the patient the housekeeper; she really had a sort of life of drudgery (at least some people consider it that) ... This girl, who is essentially a day dreamer, of the meek and lowly, pondering type, who has thought a great deal about Lourdes, gradually and insidiously developed what Bleuler describes as the “artistic method of

⁶³ Ibid.

⁶⁴ For Meyer, the process of interpreting the individual story of the patient into a ‘pathology’ of illness was ‘the reduction of the actual forces at work in the patient, the interplay of concrete factors and events, to terms of constituting as completely as possible a controlled experiment’. Meyer ‘Pathology’ p. 113.

⁶⁵ Meyer ‘Pathology’ pp. 112-115.

thinking”, wove a fairy tale of which she is the central figure, and came to believe that through her this great Advent would take place.

Dr. Harrows. “Do you think there are probably a number of people going about with similar ideas.”?

Dr. Henderson. “I do. Take our gentleman in the West House who periodically says ‘I am the Messiah. I am here for a special purpose, I am going to reclaim the world’. In contrast to that, he has been a drug addict, an alcoholic, a failure in every sense of the word. Yet his compensation is that through him a regeneration is going to take place ... It is very much the same mechanism in the one case as in the other. It is in the nature of a fulfilment of a wish”.⁶⁶

The following section sets out to explore the processes by which plans for treatment, diagnoses and prognoses were formed. During the staff meeting, the discussion of such matters did not occur in any strict order, and the conference often moving back and fourth between such topics as ideas were aired, debated, revised or restated. Yet for the purpose of analysis, these three topics are discussed below under distinct headings, beginning with diagnosis and prognosis, and finally that of treatment.

Diagnosis

Dr. Stewart.

Dr. Stewart remarked that despite the wrinkles, the patient’s face showed a certain mask-like appearance; it was not, however, the typical G. P. face... The condition struck Dr. Stewart as being quite definitely something organic...

Dr. Whitelaw

Dr. Whitelaw stated that in the cerebro-spinal fluid there was a low cell count. The condition, he thought, did not suggest an acute meningeal infection. There was a slight positive Wasserman. The colloidal gold preparation used in this colloidal gold reaction test was a very sensitive one. Dr Hastie had remarked that he was falling to one side – to the left side and backwards ... Dr. Henderson. “It is evidently a definite paresis; he has evidently got a chord involvement.”... Subtentorial gumma was suggested by Dr. Whitelaw.

In conclusion, he said that he considered the condition to be more like a gumma than a ~~cerebro-spinal~~ *vascular syphilis*.

Dr. Matheson.

“The seriological findings are; the low cell count; very weak Wasserman: the globulin doubtful, and the paretic curve of the colloidal gold reaction.” Dr. Matheson

⁶⁶ Case notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

agreed with Dr. Whitelaw that some preparations were more sensitive than others, ...
“I think, in agreement with Dr. Hastie, that the condition is in the nature of a cerebral spinal syphilitic disturbance rather than general paralysis or gumma.”⁶⁷

For those patients who suffered from ‘organically definable disorders’, most commonly associated with the ‘alcoholic psychoses’, drug addictions, ‘syphilitic’ infection, ‘traumatic psychoses’ and the ‘psychoses of senility’, the presence of Dr Whitelaw, (director of the Western Asylums Laboratory) within the staff meeting, materially aided Gartnavel’s staff in the process of diagnosis. Whitelaw was employed by Henderson to bring the work of Gartnavel into closer contact with the expertise of laboratory-based medical research, and he soon proved himself skilled in the identification of a number of organic disorders through the recognition of the symptom picture, the laboratory testing of bodily fluids and, in cases of the deceased, the morbid anatomical investigation of bodily tissues.⁶⁸ In staff meetings, such as the above quoted case, the identification of organic disease entities relied primarily upon physical examination and laboratory testing. The Wasserman test, as well as Lange’s Gold Reaction test, enabled Gartnavel’s practitioners to debate over the precise nature of the infection, with Henderson concluding that “[T]he only thing ... that would help one in diagnosis” was further testing of the “fundi of the eyes” and of the ‘cerebro-spinal fluid’.⁶⁹

Despite advances being made in the serological identification of a small number of organic diseases, for the most part the process of diagnosis nonetheless lacked such predictability and experimental accuracy. Indeed, while the identification of mental disorders was slowly moving away from concepts of lesions, hereditary degeneracy and auto-intoxications to dynamic conceptualisations of the neuroses, the schizophrenias and the psychiatry of childhood, the aetiological picture of mental illness was growing increasingly complex and uncertain. Looking to Henderson’s first annual report of 1921, he wrote of the pressing need to redefine pre-existing classificatory systems.⁷⁰ To ‘glance over the reports of the various mental hospitals throughout the country’, wrote Henderson, is to expose:

⁶⁷ Case no 123 GB812 HB13/5/179/23 NHSGGCA.

⁶⁸ D. K. Henderson ‘Report of the Physician-Superintendent for the Year 1923’ p. 25.

⁶⁹ Case no 123 GB812 HB13/5/179/23 NHSGGCA. For a technical discussion of the Wasserman Test and Lange’s gold Colloid Reaction Test see Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 303-305. Both tests involved the extraction of cerebro-spinal fluid from the patient, and this sample was introduced to various preparations. After heating these preparations distinct reactions could occur, indicating whether or not the patient’s cerebrospinal fluid indicated the presence of syphilis.

⁷⁰ Within 1921 Henderson wrote of the classification of mental disorders that ‘this year a new departure has been made, and a grouping of mental disorders has been introduced which, I believe, is more in accordance with modern ideas. A glance over the reports of the various mental hospitals throughout the

... a striking and unfortunate state of matters, in that as regards classification each institution seems to be a law unto itself, and in consequence there is no uniformity.⁷¹

What was described as a case of ‘confusional insanity’ in one mental institution, may, warned Henderson, have been termed ‘dementia praecox’ in another. Classification, wrote Henderson and Gillespie, when used properly, ‘is useful and even necessary ... for the compilation of a uniform set of statistics by institutions and administrative authorities’, but Henderson inherited a classificatory system from his predecessor, Llandel Rose Oswald, that sorted out the institution’s patient population under diagnostic groupings made defunct by North American and German classificatory systems.⁷²

To make ‘comparison possible’ with modern diagnostic groupings, Henderson rejected classificatory terms used by his predecessors such as ‘mania’, ‘melancholia’ or ‘stupor’, and introduced into Gartnavel a classificatory scheme ‘in accordance with modern ideas’ that was essentially Kraepelinian.⁷³ Bringing Gartnavel’s classificatory system up to modern standards, Kraepelin’s diagnostic entities offered uniformity and a greater degree of clinical acumen, but, as individual patient cases continued to arise whose symptom pictures failed to fit neatly within the predefined, ‘rigid symptomatological nosology of the Kraepelinian school’, Henderson emulated Meyer by terming these classifications as reaction types, rather than as uniform disease entities.⁷⁴ In doing so, transcriptions reveal that Henderson resisted the over-deterministic theories of Kraepelin, which aligned so firmly the diagnosis of a patient to a predefined prognosis.

country is sufficient to reveal a striking and unfortunate state of matters, in that as regards classification each institution seems to be a law unto itself, and in consequence there is no uniformity’. Henderson ‘Report of the Physician-Superintendent for the Year 1921’ p. 15. See also Smith and Swann ‘Medical Officers and Therapeutics, 1921-1993’ p. 73.

⁷¹ Henderson ‘Report of the Physician-Superintendent for the Year 1921’ p. 15.

⁷² Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 15-16.

⁷³ In 1920, as Llandel Rose Oswald’s failing health had necessitated Henderson to act as Physician-Superintendent, Henderson inherited a classificatory system which was upheld by the British Medico-Psychological Association’, but which he considered out-dated and unworkable. For a comparison of these two men’s classificatory systems see the *One Hundred and Seventh Annual Report of the Glasgow Royal Mental Hospital for the Year 1920* p. 34 which was compiled under Oswald’s physician superintendence and the *One Hundred and Eight Annual Report of the Glasgow Royal Mental Hospital for the Year 1921* p. 33 which compiled under the physician superintendence of Henderson. See also Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 19-20. See also Smith and Swann ‘Medical Officers and Therapeutics, 1921-1993’ p. 73.

⁷⁴ Henderson ‘Introduction’ *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* p. xi.

Across the decade, Henderson refined and reinvigorated classificatory terminology, yet by 1932 Henderson and Gillespie maintained that there was still no one classificatory system that was ‘entirely satisfactory’. Despite bringing Gartnavel’s classificatory system into alignment with Continental and North America diagnostic groupings, when it came to diagnosis, this was often most cautiously formed. “[D]iagnosis”, or the placing of a patient in the appropriate class’, was considered by Henderson and Gillespie, to be ‘on an unstable foundation’, and staff meeting transcripts reveal many cases which received no formal diagnosis until after several months of further examinations and treatment. ‘[F]ortunately’, they wrote in characteristically Meyerian terms, ‘it is not diagnosis that matters, but the understanding of the disorder, and of the patient who suffers from it’.⁷⁵ Following the Meyerian dictum that mental illness is to be regarded as ‘different *types of reaction*’, enquiry into the personal, social and environmental situations of individual patients was of paramount importance.⁷⁶ ‘In Adolf Meyer’s words’, echoed Henderson and Gillespie:

... it is not the patients we are to sort out, but the facts; and while ... case records will be arranged in groups for the sake of more or less systematic description, the disorders exhibited will be considered as the individual reactions of a specifically endowed, and often constitutionally loaded, organism to the environment.⁷⁷

Unsurprisingly, discrepancies between Henderson’s published works and the reality of clinical practice emerge through the analysis of staff meeting transcripts. It becomes evident that, while Henderson endeavoured to inculcate a dynamic approach to the care and treatment of Gartnavel’s patients, his staff did not always adhere to dynamic principles; and while the staff meeting was intended to facilitate democratic consultation, Henderson also used the meeting as a place to instruct, question and at times criticise his more junior medical officers. Moreover, despite Henderson’s efforts to establish uniformity in the use of diagnostic terminology, his staff did not always reach a consensual appropriation of such terms. To reinforce his dynamic principles and instil a coherent usage of diagnostic terms, the following transcripts show that Henderson indeed used the

⁷⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 20.

⁷⁶ In a lecture given by Meyer he advised his students ‘do not think that the name embodies the knowledge and definition’, but rather ‘you have to know your cases, and if you do, the name will be a secondary matter’. Adolf Meyer *Ninth Lecture, Dementia Praecox* Box I, Series XV AMC. Quotation taken from Lamb ‘Pathologist of the Mind’ p. 205.

⁷⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 20. As chapter eight goes on to demonstrate, it was in part through Henderson’s engagement with individual patients and their life stories that he was able to challenge British diagnostic categories; to reinvigorate his approach to classification and redefine certain diagnostic entities with far reaching effect.

staff meeting as a teaching environment in which to demonstrate the practical implementation of the reaction-type diagnosis to individual cases.

For instance, in the case of one patient, a Miss Edith Perkins, who was admitted in 1923, Henderson concluded the staff meeting by advising the board to ‘look on such an illness, as did Meyer, as a reaction to a situation’. During the staff meeting Gartnavel’s medical officers had debated over the diagnosis, offering ‘hysteria’, ‘neurasthenia’, ‘psyaesthesia’ and ‘confusional state’ as possible classifications, but Henderson resisted positing a definite diagnostic category, saying that in a case such as hers it was of little importance to secure a diagnosis:

... one must avoid thinking of any specific entity; - it was a question of thinking in a constructive way of all the different factors, thinking of how one could help her to meet her difficulties, irrespective of manic-depressive, dementia praecox, etc.⁷⁸

In the case of an elderly female patient, named Jessie McBride, admitted to Gartnavel in 1926, Henderson likewise advised his fellow colleagues to offer a less dogmatic analysis of the case. When a colleague used diagnostic terminology that did not correlate to that which was used by Henderson, Henderson showed more of an abrupt, indeed critical response to his colleague’s diagnostic formulations. Dr Skottowe stated within the staff meeting that “I would call it confusional insanity”, but Henderson replied “I don’t think there is such an entity. I don’t know what you mean”.⁷⁹

While Henderson used the staff meeting as a teaching environment, his dynamic diagnostic formulations were sometimes in opposition to the prevailing thought of British psychiatry. In a number of cases Henderson found himself challenging the views of colleagues who adhered more strongly to the prevailing, increasingly somaticist, rather than dynamic interpretations of mental disorder, and Henderson therefore pushed his colleagues to recognise the complex, often mutually dependent, roles played by both organic and psychological factors of causation.⁸⁰ For instance, in 1923 Mary Noble was brought in 5

⁷⁸ Case notes no 132 GB812 HB13/5/179/32 NHSGGCA. Mental illness, within this context, was therefore envisaged as something much more complex than that envisaged by Kraepelin or Clouston. As Chris Philo writes in unpublished working notes, the ‘illness type’ was not a ‘straightforward, self-contained, self-occurring ontological entity/phenomena’ but rather, mental illness only came to be recognised as a ‘type’ when contextualised against an ‘external environment’.

⁷⁹ Case no 468 GB812 HB13/5/185/3 NHSGGCA.

⁸⁰ For Henderson’s published criticism regarding the aetiological significance of bacterial toxins and focal infection see Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 54.

weeks after the birth of her first child, and it was noted in the medical certificate that she had undergone a ‘marked change in her conduct’ a few days after the birth. She had refused to recognise the child as her own, whilst she showed a strong ‘revulsion of feeling’ towards her husband, and the case, which was presented one month later in the staff meeting by Dr Baird, was initially classified as a case of toxaemia. Dr Dawson proposed that a gynaecological examination be undertaken to ascertain whether a ‘displacement’ had occurred, as there was ‘a lot of talk about reflex mental conditions arising from such minor things as displacements’, but for Henderson, he considered it unwise to classify the case as one of toxaemia ‘right away’.⁸¹

‘[U]ndoubtedly’, stated Henderson, there was a definite physical cause, but taking the woman’s previous personality into account, he considered that the case be looked upon more ‘as one of manic-depression, on the basis of a pregnancy’. The patient, he emphasised, had previously been a ‘bright, active, popular woman’. ‘He contrasted her school and office life with her married life’, and it was this latter domestic environment which Henderson suggested had been ‘rather a disillusionment to her’. ‘Her attitude of hatred towards her husband’ indicated to Henderson that her condition was ‘more or less a reaction to a set of circumstances that had been difficult’:

... in her case a very careful personality study should be made in order to ascertain what her mode of reaction to difficulties, etc, has been, how it was that she had reacted in this particular way to such a thing as a childbirth.⁸²

While Henderson steered his colleagues away from too materialist a line of thinking, during another staff meeting conducted by Dr MacNiven in 1925, Henderson once again offered an uncompromising rebuttal to his colleagues’ diagnostic formulations:

Dr. Harrows. “What would you suggest as a diagnosis”?

Dr. Macniven. “Chronic neurasthenia”?

Dr. Henderson. “No ...”

⁸¹ In the *Annual Report* of 1923 Henderson wrote that ‘It is still held by some that toxic factors are largely responsible for all types of mental disorder, and that if these factors could be eliminated our recovery rate would go up by leaps and bounds. I do not believe this is so’. In accordance with that which is expressed by Henderson in the above noted case, he wrote that ‘Mental disorder is much too complex a subject to be explained in such a simple way’. Rather than account for this female patient’s illness on the basis of toxic infection, as was proposed by Dr. Baird and Dr. Dawson, Henderson concluded that this was one, but not the most significant factor in the case.

⁸² Case notes no 155 GB812 HB13/5/179/55 NHSGGCA.

This in itself is demonstrative of Henderson's direct, no nonsense approach, but what is most interesting here is the opposition shown by Henderson towards Kraepelinian diagnostic formulations. As the case continued, Henderson suggested that it be grouped 'along with the agitated, involuntional depressions', to which Mr. Bankhead, who was acting as a clinical clerk, asked:

Mr. Bankhead. "Are not involuntional depression in the same group as the manic-depressives.?"

Dr. Henderson. "I do not agree with that. I think the involuntional group is a group that should be kept apart from the manic-depressive group: I think they are distinctive. I do not think that in involuntional cases we get anything like the type of personality of a manic-depressive".

Mr. Bankhead. "Kraepelin's opinion was that they should be grouped together"

Dr. Henderson. "I know, but I do not agree with it".⁸³

In other cases, Henderson found himself more in agreement with his colleagues. In one staff meeting, conducted in 1923, the board mutually criticised the approach of medical practitioners outside of Gartnavel, who, it seemed, had failed to take the mental factors of a case into account. The patient, named Jeannie Gove, was admitted to Gartnavel aged 19, with a history of physical ill health. She suffered from 'chronic ear trouble' and latterly had undergone the removal of her appendix, but this surgical procedure, suggested Dr. Baird, was probably too readily done. After concurring that the appendix was 'probably a healthy one', 'Dr. Henderson' indicated to the board that surgeons 'did not often enough take into account the nervous and mental factors' which contributed to organic disorders.⁸⁴ Within the staff meeting Miss Gove said that a general practitioner had suggested that her ear infection was "going to her brain", and had spoken of the necessity of having it "operated on". This misguided remark, agreed the board of medical officers, 'had undoubtedly had a harmful effect on her'.⁸⁵

The necessity of carrying out a full assessment of the 'facts' before finalising a pathology or offering a diagnosis was impressed upon Meyer's students, and it is clear that Henderson emulated this approach. Meyer wrote that the Physician-Superintendent was to 'hold' his medical officers to reporting 'statements of fact'; and, when a diagnosis was

⁸³ Case notes no 318 GB 812 HB13/5/182/28 NHSGGCA.

⁸⁴ For Meyer, he similarly wrote that surgeons would 'do well always to enquire' into the psychological, as well as the purely physical aspects of bodily ill health. 'misbehavior of the heart, the thyroid, the vegetative nervous system ... may, in spite of appearances, actually indicate significant personality developments, such as anxiety states or fears'. Meyer 'Therapy' p. 158.

⁸⁵ Case notes no 132 GB 812 HB13/5/179/32 NHSGGCA.

offered, this was to be based upon a clear presentation of the known factors that pointed towards the causes, processes and likely outcome of the case. ‘If you hold yourselves and your assistants strictly to a critical statement of fact’, avowed Meyer, ‘and to less expression of surmise and opinion’, the analysis of the case was considered to be upon ‘perfectly safe ground’.⁸⁶ If, as is demonstrated in the case below, Gartnavel’s medical officers formulated an interpretation that Henderson considered to be based upon mere conjecture, he readily took it upon himself to point towards the perceived failings of his medical officers and direct them towards a dynamic analysis of the case.⁸⁷

Asked if he had any further observations to make on the case, Dr. Skottowe said, “This case, to me, is a very good example of how a man’s whole content of thought may be modified by his mood. It is very striking to me that he presumably had, and was aware that he had had, syphilis thirty-three years ago, and that it has never bothered him until now. I think the only explanation that one can put forward to account for it is that owing to possible organic and endocrine changes there has been a variation (?) in his mood, and his thoughts have become rather distorted...

Dr. Henderson. “You think it is the mood that has dominated the thought, and not the thought that has dominated the mood? ... How can you prove that?”

Dr. Skottowe. “From the man’s own words – an awful depression came over him.”

Dr. Henderson. “Why should he have gone on for thirty-three years? Is it not more reasonable to suppose that his intellectual changes have dominated his mood? I think you are arguing on very little definite ground.

Dr. Skottowe. “I do not think one can blink at the fact of the endocrine at that period”.

Dr. Henderson. “These things also come in undoubtedly. There are various things, and it shows you how impossible it is to dogmatise. In your mind the explanation has seemed relatively simple. You have put forward a rather beautiful idea that one thing has followed another ... I think it is unfortunate to dogmatise ... and to feel that one has an explanation ... it is much better to say that these are the factors; and leave it at that ... If you do it in that way, I think it leaves your mind much more open to the possibilities of continued explanations”⁸⁸

In cases such as this where Henderson offered a forceful rebuttal to a colleague’s interpretation, Henderson’s more open-ended analysis brought the staff meeting to a close. Yet, despite the authority held by Henderson to determine the conclusive outcome of the staff meeting, Gartnavel’s medical officers could, and did, nonetheless challenge Henderson’s interpretation of a case. During a staff meeting, conducted in 1925, the

⁸⁶ Meyer ‘Discussion of Cooperation Between the State Hospitals and the Institute’ pp. 126-27. See also Meyer ‘Pathology’ *Psychobiology, A Science of Man* p. 112.

⁸⁷ Meyer ‘Discussion of Cooperation Between the State Hospitals and the Institute’ pp. 126-27.

⁸⁸ Case notes no 409 GB 812 HB13/5/184/6 NHSGGCA.

transcript shows Dr Skottowe and Henderson once again coming into conflict over diagnostic terminology:

Dr. Henderson. “What is your understanding of the situation”?

Dr. Skottowe. “To my mind, I think the biggest factor in his breakdown is his constitution. I think he has always been of a rather schizoid make-up. You cannot blink at the fact of his bad family history, and I think one of his biggest difficulties has been his fear of transmitting mental illness; ... I would call it a schizoid-depression”.

Dr. Henderson. “Is there such a thing”?

Defending his position over choice of diagnostic terminology, Skottowe highlighted several factors regarding the patient’s personality and behaviour that had gone unobserved by Henderson within the staff meeting. Skottowe’s observations of the patient upon the ward had revealed a marked fluctuation of the patient’s characteristic mannerisms. The ‘gentlemanly bearing’ displayed by the patient to Henderson within the staff meeting was contrasted by Skottowe with the patient’s periodic use of foul language upon the ward, and these differential view points initially produced two very dissimilar accounts of the symptomatology of the case.

Dr. Skottowe. “He is depressed, but there is a big split in his personality: he is disintegrated – he is nothing like what he was”.

Dr. Henderson. “Intellectually he has not disintegrated”.

Dr. Skottowe. “When a man says that a railway whistle is the voice of Dr. Ronaldson accusing him of various thing – then this business of seeing Christ in his room, and you ask him what was Christ like, and he says “Oh, he was very nice” (in his most indifferent, casual voice) – to my mind that speaks more than half the case record, I think it evident of a great falling away”.

Dr. Henderson. “It is more a falling away in his emotions rather than in his intellect. He is very clear in many ways, he is very well preserved, his gentlemanly bearing is retained ... Although he has been the shy, dreamy kind of non-leader type, he has many features that make me think of a manic-depressive type. And superimposed on that, either way you look at it, - it is one of these conditions where Bleuler might say “here is a manic-depressive with schizoid, or here is a schizoid with manic-depressive features”.

Dr Skottowe. “I agree about the manic-depressive features”.

Dr. Henderson. “It is really a case where if one liked to emphasise certain aspects, why should not one for grouping purposes look on it as a mixed manic...”

Dr Skottowe. “There is a big split. There is a pretty gradual emotional deterioration; he does not care if he were to stay here for the remainder of his days: he would be quite happy if he thought he had to go to prison”.

Dr. Henderson. “He feels that he has done wrong. He feels that it was a gross injustice he was not sent to prison; he is always blaming himself and is very apologetic for having inflicted himself on us”.

Dr Skottowe. “In regard to what you were saying about his gentlemanly bearing: - when he is in what he calls a “bad temper” his language is something dreadful”.⁸⁹

With the above quoted dialogue evidencing reluctance on the side of either man to come to a unified agreement as to the nature of the overall diagnostic grouping, this demonstrates most clearly that the staff meeting was a place for debate and discussion, rather than instruction alone. The preservation of such ‘table talk’ reveals the staff meeting was in many ways a clearing house for the individual, sometimes disparate, views of Gartnavel’s medical officers; and while transcripts underscore the tensions, disagreements and the unequal dispersion of power that flowed within these meeting, they simultaneously reveal a degree of freedom afforded to Gartnavel’s medical officers to air their opinions and seek consultation. In a number of cases Henderson’s views do dominate the discussion, and this has formerly been interpreted as the authoritarian stance of Henderson enforcing his own interpretation of the case upon his colleagues,⁹⁰ but this, I would suggest, misses the overriding purpose of the staff meeting. Transcripts suggest that Henderson used the staff meeting as a place to instruct and advise, as well as to be informed by his colleagues, and that the overriding function of the staff meeting was to instil a sense of cohesion and to unite in purpose and action Gartnavel’s staff. The most credible of ideas, rather than a single voice with the most seniority, produced a revised, and often mutually consensual, summary of the case, and therefore diagnosis, prognosis and plans for future treatment were each the product of rigorous debate. ‘Nothing’, wrote Meyer of the staff meeting, ‘is so promotive of clearness of thought and definition of work’:

... as such a presentation of the facts under the critical eye of all the physicians of the hospital. Inconsistencies and flaws of observation, indifference about the procuring of information, looseness of diagnostic reasoning, ignorance of the real practical issues of psychiatry, are thus eliminated in a way that is bound to make the work interesting, and profitable to patient and physician alike.⁹¹

⁸⁹ Case no 631 GB812 HB13/5/187/31 NHSGGCA.

⁹⁰ Smith and Swann write that Henderson had ‘considerable trouble persuading his juniors about the virtues of the psychobiological model, and that his resolutions of these sessions did not always show a democratic respect for consultation’. ‘Medical Officers and Therapeutics, 1921-1993’ p. 73.

⁹¹ Meyer, excerpt from the ‘Eighteenth Annual Report of the State Commission in Lunacy, September 30 (1906)’ 59-66, reprinted in *The Collected Papers of Adolf Meyer, Volume II, Psychiatry* p. 149-50.

In the vast majority of staff meeting transcripts sampled, they reveal a democratic airing and subsequent re-envisioning of opinion. Indeed, as the following transcript makes clear, Henderson could be the first to admit when he himself had overlooked certain ‘facts’ of observation, readily incorporating the opinions of others to reformulate his view of a case:

Staff Meeting, ... January, 1925 – Dr Harrowes.

Q. How is your headache? A. “Aching pretty badly”...

Q. Do you feel better than you were? A. “Oh, yes”....

Q. Do you feel anxious or frightened?

A. “Sometimes I feel frightened” ... I am feeling entirely different”.

Q. In what way?

A. “In my whole character. I used to be very precise – very precise in my clothes and everything I did, and I did not seem – (long pause) I was never afraid”...

Dr. Thompson. “I think the anxiety symptoms – I think the fear is a big factor ...”

Dr. MacNiven. “In some ways he reminds one of neurasthenia. I think there are other things that you cannot account for without thinking of some organic thing, tumour or something like that”.

Dr. Henderson. “It did not cross my mind”.

Dr. MacNiven. “Is epilepsy out of the question”.

Dr. Henderson. “Traumatic epilepsy.”?

Dr. Whitelaw. “What about the question of it being shell shock concussion? – The big explosion ... causing minute haemorrhages, such as I have seen specimens of”.

Dr. Henderson. “So have I, but I have never seen an interval elapse, with returned function, such as this chap showed; ... I think we should get the eye-grounds examined ... The thing that strikes me – although the anxiety is a feature, back of it, I feel that we are dealing with a man whose brain has been definitely injured in some way; there has been a definite organic process.”

Dr. MacNiven. “The nature of his mental symptoms, delusional, stupid conduct, with the memory defect”.

Dr. Henderson. “Yes”.

Dr. MacNiven. “You get these blanks in hysteroid things”.

Dr. Henderson. “You do, but I do not think you get the lack of insight”.⁹²

Prognosis

In making a prognosis of a case, the board relied greatly upon the pathology that took into account the patient’s past, and their most recent ill-adapted tendencies, while the personality study also enabled Gartnavel’s medical officers to judge the modifiability and

⁹² Case notes no 302 GB812 HB13/5/182/12 NHSGGCA.

plasticity of the patient's adaptive tendencies. In cases that originated from tangible infective agents or organic, degenerative processes, prognosis was often closely aligned to the diagnosis itself, and therefore Gartnavel's practitioners constructed a case around a uniform and relatively predictable pattern of cause and effect.⁹³ But, as Meyer wrote in 1933:

Man is an entity that does not respond in an invariable manner. Even in the organically definable disorders, only a limited number of performances are constant and obtainable in a uniform manner at all times. Almost all reactions are apt to vary somewhat from day to day, and a large number are bound to be relatively unpredictable ...⁹⁴

When psychiatrists were met with such unpredictability, Meyer wrote that, by viewing mental disorders as reaction-types, prognoses could nonetheless be made upon the basis that reactions are 'reasonably true to type if one makes allowance for the obligatory relation to situation and the personality'.⁹⁵ Staff meeting transcripts from Gartnavel demonstrate Henderson's close alignment to such principles, with the following excerpts showing the close congruence between Henderson's broad diagnostic methodology and that of Meyer.

In the case of Isabella Crawford, admitted in 1926, it was noted she became depressed around the involutorial period (menopausal years). Henderson reasoned that with 'the attack coming on at this period of life', this made both the diagnosis and prognosis fairly clear. 'The prognosis', it was recorded, 'was thought to be fairly good, the causative factors being quite definite, but it was felt that the illness was unlikely to clear up in a less period than eighteen months or two years'.⁹⁶ In another case, quite the opposite case of affairs was seen to be conducive of a positive prognosis. Annabella Smith, who was merely 17 when she met the board in 1925, had been exhibiting many signs of the dementia praecox reaction-type since she was aged 15. The fact that such a type of illness rarely came on at such an early age gave Henderson hope that she was still 'pliable', and that by

⁹³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 293. See also Adolf Meyer 'Preparation for Psychiatry' *Archives of Neurology and Psychiatry* XXX (1933) 1111-25, reprinted in *The Collected Papers of Adolf Meyer, Volume III, Medical Teaching* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) p. 82.

⁹⁴ Meyer 'Preparation for Psychiatry' p. 82.

⁹⁵ *Ibid* p. 82.

⁹⁶ Case no 511 GB 812 HB13/5/185/46 NHSGGCA.

bringing her ‘under supervision at this early stage’ she could be guided to take up ‘better mental habits’.⁹⁷

With the process of providing a prognosis dynamically intertwined with the observations taken from the personality study, the pathology, the various therapies and diagnostic formulations, each subsequent staff meeting could necessarily reveal a revised prognostic formulation. Patient’s reactions to certain treatments and therapies were particularly useful as indicators from which further to refine the prognosis, and so this naturally takes us on to the analysis of the treatment plan that was constructed within staff meetings.

Treatment

Dr. Knight. “Have you any suggestion as to treatment”?

Dr. Henderson. “I have not. I think in a case like this it is a question of trying to get her to cooperate as much as one possibly can...”

Dr. Knight. “In a case like this don’t you think you might get more information by hypnotism”?

Dr. Thompson. “Would she let you hypnotise her”?

Dr. Henderson. “I suppose one might”.

Dr. Harrows. “I don’t think she is suggestible, in the first place: in the second place, I don’t think she would allow you. It would be dangerous to attempt it. I think it would do her harm”.⁹⁸

Although plans for future treatment were sometimes discussed with the patient in the staff meeting, after their departure a more in-depth consultation followed in which the value of different treatment plans was often debated. In cases where there was a definite organic disturbance underlying the patient’s condition, treatment ranged from a proposed regime of exercise and intake of nourishment to the prescription of drugs. In the case of a patient whose mental disorder stemmed from syphilitic infection, which was then complicated by a head injury, the plan of treatment was simply to carry on the ‘intramuscular ... injections of Bismuth’. ““What would you push it up to”?” enquired Dr Knight; “I would push it up to the extent of trying to get his Wasserman negative”, replied Henderson.⁹⁹

⁹⁷ Case notes no 331 GB812 HB13/5/182/41 NHSGGCA. We hear here how prognosis, unlike within Kraepelin’s classificatory system, was not based upon diagnosis alone, but took in other possible factors such as age, organic processes etc.

⁹⁸ Case notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

⁹⁹ Case notes no 281 GB 812 HB13/5/181/49 NHSGGCA.

When formulating such plans for treatment, comparable cases were often kept in mind. In the above quoted staff meeting (case no 330) conducted in 1925, Henderson, alongside Drs. Knight and Harrows, debated the value of hypnotic treatments; and within this discussion the experiences, held by each medical officer, of previous encounters with former patients made up the staple topic of conversation. Knight voiced most keenly her wish to attempt hypnotic therapy on this patient, due to her former success with another patient. In the following excerpt from a staff meeting, Knight described the circumstances under which hypnotic therapy was previously used with success, reflecting the common sense approach demanded by Meyer by which the psychiatrist ‘mobilizes actually experienced material for ... successive discussions’.¹⁰⁰

Dr. Henderson. “As a matter of fact I never have used hypnotism, and, perhaps, I should not criticise it. My feeling is that it is a dangerous thing to use in a case such as this ... With a logical mind such as she has, I do not think that the mere telling her during the hypnotic state that her ideas are not facts would be sufficient ... The only men I know who practised it have nearly all discarded it. Dr Ernst Jones of London has absolutely discarded it – Freud, Jung ...

Dr. Knight. “... At the same time, I have had one or two cases with good results.”

Dr. Henderson. “Cases of this particular type”.

Dr. Knight. “No. The case that comes to my mind is that of a man who worked in a yard. He imagined that a mould of a boiler was going to fall on him or on a fellow-worker ... It fell, as a matter of fact ... The patient ... fell violently sick, was taken home ... When he reached his home he behaved in a confused, agitated manner... After three days he became excited ... he had no sleep for a couple of nights. He was then hypnotised, the whole thing was readjusted ...”¹⁰¹

In this case Henderson rejected Knight’s suggestion that hypnotism be carried out; comparisons, argued Henderson, could not adequately be drawn between the success of hypnotic treatment on the former case, and the probability that it could be used with similar results in the present case. Nonetheless, while Henderson often resisted attacking the problem at a subconscious level, in cases where a patient’s personality was seen to exist inharmoniously with their environment, Henderson endorsed therapies that aimed to readjust a patient’s reactions upon a conscious level.

¹⁰⁰ Adolf Meyer ‘The “Complaint” as the Centre of Genetic-Dynamic and Nosological Teaching in Psychiatry’ in *The Collected Papers of Adolf Meyer, Volume III, Medical Teaching*. (Paper originally published in 1928 in *New England Journal of Medicine* CXCIX 360-70) p. 3.

¹⁰¹ Case notes no 330 GB 812 HB13/5/182/40 NHSGGCA.

In the case of a teenage patient mentioned earlier, Jeannie Gove, whose case records revealed a history of physical illness, difficult home conditions, and ‘auto-erotic habits’ being carried out at an ‘early period of time’, Henderson suggested that, if the aetiology of neurasthenia, as proposed by Freud, were accepted, then treatment depended a great deal upon occupational therapy and psychotherapeutic conversation:

The case, Dr Henderson said, brought up many interesting things, and he advised to look on such an illness, as did Dr. Meyer, as a reaction to a situation ... It was not so much a question of giving her drugs, or even of specified occupations as of taking all the factors and forces of her personality into account and harmonising them in a way they had never been harmonised before. Occupation was important, and bringing her into touch with such a person as Miss Robertson should have a beneficial effect, but these things must be backed up by talks with the doctor ... These psychotherapeutic conversations should be repeated over and over again until actually driven home

...¹⁰²

While this plan of treatment depended very much upon an intense readjustment of this young patient’s reactive tendencies, for older patients it was more often the case that they were considered too elderly to undergo a “...radical cure”, and therefore less interventionist plans of treatment were devised. In the case of the aforementioned mine inspector who developed an intense fear of going down the mine shaft cage, Knight once again suggested that this might be ‘one of the rare cases where’ the patient might benefit from ‘hypnotism’. But to this Henderson replied, “He is fifty years old, and I think we must content ourselves with a surface readjustment”. Although the board debated whether an Oedipus Complex played a vital factor of causation, his age, Henderson impressed upon the board, necessitated that they simply ‘attempt to regulate his periods of rest – week ends more frequently, and try to improve his physiological condition as much as his psychological one.’¹⁰³

As well as talking therapies, drug therapies and the promotion of rest and recreation being considered forms of therapeutic treatment, changing a patient’s immediate environment was also considered to hold significant therapeutic benefits for a number of patients. With Meyer’s therapeutic strategy relying upon the patient to subscribe to the social reality of the hospital, its attendant staff and patients, the movement of a patient from one part of the

¹⁰² Case notes no 132 GB 812 HB13/5/179/32 NHSGGCA. The role of Miss Robertson, the occupational therapy instructor, will be explored in the proceeding chapter 7.

¹⁰³ Case notes no 234 GB812 HB13/5/181/2 NHSGGCA.

hospital to a different wing or ward was considered a possible therapeutic agent. Socialising the more promising of patients with those who were better behaved, in more comfortable or engaging environments, was a tactic used to coerce the patient to adopt the behaviours of their fellow patients. Henderson replicated this form of treatment, as demonstrated in 1923 in the staff meeting attended by Meyer:¹⁰⁴

Dr. Meyer “I think I would direct all my effort towards developing his individuality. Sometimes one can start afresh.

Dr. Henderson. “We thought it might be accomplished in this way. He was here in the East house, and I suggested to his wife that we should give him a change of environment, bring him into touch with different nurses, different patients, etc. - ... He was taken over to West House, and the second day after being there he was much spruce and smarter – said to Dr. Dawson that he was now really all right, that he was associating with decent people, that he was going to make himself smarter, dress better, play games, etc. This morning he is back to his old East house-appearance – not very tidy, etc.¹⁰⁵

An archaeology of silence

Among the rich array of narratives preserved within staff meeting records, a history – indeed, as Foucault would have it, ‘an archaeology’ of ‘silence’ - has likewise left its imprint within staff meeting records.¹⁰⁶ For a number of patients, their records reveal they actively resisted participating in the staff meeting. Some sat in their beds and refused to be brought down, while some became impassioned and destructive. Others expressed terror, confusion or discomfort, causing Gartnavel’s medical officers to disband their efforts, resulting in gaping holes in the documentation. In the case of a Miss Dixon, it was recorded that the:

Patient was not present, on account of the fact that she became impulsive and destructive to her clothing when an attempt was made to bring her down from the ward.¹⁰⁷

For another patient named Miss Beveridge it was recorded that she ‘was not present, having refused to come down’.¹⁰⁸ For other patients who found the staff meeting a stressful

¹⁰⁴ Adolf Meyer excerpt from the ‘Twenty-First Annual Report of the State Commission in Lunacy, Sept 30, (1909)’ reprinted in *The Collected Paper of Adolf Meyer, Volume II, Psychiatry* ed. Eunice Winters (Baltimore: The Johns Hopkins Press, 1951) p. 162.

¹⁰⁵ Case notes no 229 GB812 HB13/5/180/69 NHSGGCA.

¹⁰⁶ Michel Foucault *Madness and Civilization* (Oxon: Routledge, 2009) p. xii.

¹⁰⁷ Case no 155 GB812 HB13/5/179/55 NHSGGCA.

or unsettling experience, records reveal that Gartnavel's staff could cut short the examinatory process. In the transcript of one patient, Henderson's line of questioning was directed towards the patient's previously voiced belief that her husband was putting poison in her food, to which the patient was recorded as having become 'very stressed and agitated, and Dr. Henderson did not question her further'.¹⁰⁹

In cases such as these, staff meeting records preserve moments of resistance, fear or absence, but in a large proportion of cases these silences occur not because of a patient's reactions to the staff meeting environment, but because of internal, organic disturbances, which prevented patients from communicating with their practitioners:

Staff Meeting ... 1926 – Dr. Cameron

(Patient replied to only a few of the questions put to her)

Your husband was up the other day, I understand. Was he?

A. -----

Q. Was your husband up the other day? A. -----

Q. Was your husband up the other day? A. "Yes".

Q. How many days ago is it since he was here? A. -----

Q. Do you remember what day it was? A. -----

Q. Do you remember what day it was? A. "Yesterday"...

Dr. Henderson "is this retardation? Do you think it is best described as a retardation? Is there not associated with it a great dulling of comprehension?"

Dr. Whitlaw "It looks like it. Easy questions are answered".

Dr. Henderson "I think it is one of these points that one has to be very guarded in using descriptive terms. The striking thing to me is the blank expression and blank look, as if she were experiencing a certain amount of difficulty in understanding what one meant".

Q. You don't feel sad? A. -----

Dr. Henderson "I don't think one can get her to cooperate sufficiently ..."

Dr. Cameron "One would have to wait for another lucid interval"...

Dr. Henderson "I think the important thing is the organic side of it ... One does, of course, get a stuporous state with such a condition as general paralysis:..."¹¹⁰

¹⁰⁸ Case no 511 GB812/5/185/46 NHSGGCA.

¹⁰⁹ Case no 299 GB812 HB13/5/182/9 NHSGGCA.

¹¹⁰ Case no 508 GB812 HB13/5/185/43 NHSGGCA.

For research that focuses upon the illness narrative of the patient, acute organic illness is one of the many barriers that separates the inner, phenomenological worlds of asylum patients from scholarly enquiry. For those left voiceless by disease, whose staff meeting records merely preserve murmurs and mumbles, their stories rely, more than any other group of patient, upon the contemporary interpretation of Gartnavel's medical officers. Within this final section, I acknowledge these silences, and attempt to give these patients a space in which to be heard.

Cases classified as general paralysis, senile dementia and toxic-exhaustive states all demonstrate instances where patients were deprived, to differing degrees, of the ability to communicate with, or to comprehend, those around them. It is therefore from a perspective heavily weighted towards the psychiatrist, to their endeavours at penetrating the inner workings of the mind, that a history of such silences may be explored. The clinical perspective opens up analysis to the interpersonal, social, political and medical histories that contextualise such individual cases, therefore enabling researchers to focus upon the silent, yet decisive, imprint left by such patients within medical records. The following transcript of a staff meeting reveals how such silent cases may yet provide valuable insights into the diagnostic process. Following the case of Hannah Duncan, a young female patient diagnosed as suffering from encephalitis lethargica, this case facilitates a greater understanding and, indeed, appreciation of how Gartnavel's practitioners sought to empathise, understand and alleviate patients for whom organic illness deprived them of a voice.

Miss [Hannah Duncan] ...

Mental Exam. 21/3/25

When seen some hours after admission she was in bed. She lay with her head placed on her chest; her mouth half open and saliva dribbling from it. Her face is vacant and expressionless. As a rule it is immobile and shows no emotional movements. Once however she smiled. The smile appearing slowly and tending to become fixed on her face for several seconds then giving place to the usual fixed expression. Once also she cried and the face became fixed in an expression of distress which it remained without change for several seconds. She does not make any spontaneous remarks. When spoken to there is always considerable interval before she replies and her answers are almost always monosyllabic. This delay in answering is evidently not due to any difficulty in understanding what is said to her because from the examination it is apparent that her understanding is perfectly clear. Her talk is a mere mumble and almost unintelligible. In speaking her tongue hardly moves and this

combined with the difficulty occasioned by the collection of saliva in her mouth makes her talk more like a moan than anything else ... She requires to be spoon fed and she requires to be assisted to the toilet. She is clean in her habits if attended to.¹¹¹

Two years into the First World War, an illness, that would become world wide in its distribution, began to take a hold thousands of men, women, and children. Through the winter of 1916-17, in Vienna and other European cities, manifestations of the illness became so diverse and irregular that it seemed as though ‘a thousand new diseases had suddenly broken loose’,¹¹² but gradually, through the pathological studies of the neurologist Constantin von Economo, a singular disease entity was recognised. Defined by Economo in 1918 as encephalitis lethargica, or, as the British Press were commonly to refer to it, the ‘sleepy sickness’,¹¹³ it became known not only for the ‘high mortality’ rate ‘in the acute stage’ of illness, but for the array of debilitating ‘after-effects’ that scarred patients’ bodies.¹¹⁴ In July 1924, one such case is that of Hannah Duncan, a girl aged 15, who was struck down by an illness first thought to be influenza. Seeing double and experiencing a general ‘feeling of malaise’, she was sent home from her work. At home she was troubled with sleepless nights, complaining of pains in her head and ‘her bones’, and her speech was said to be ‘confused and rambling’. After three weeks she returned to her work, and appeared to be fully recovered, but in the first week of September, while the girl was sat at home by the fire taking off her shoes, she was ‘seized with a violent tremor in her arms’. Losing the use of her hands, she was sent to bed and the initial symptoms passed off, but her relatives noticed that after this attack her mouth sometimes hung open, with saliva freely drooling down her chin. Gradually the girl appeared to grow ‘dull’, her speech becoming ‘almost unintelligible’, while her facial expressions took on a strikingly altered appearance. Her limbs grew stiff, so that mobility was largely curtailed, and for six months the girl remained in this state until her admittance to Gartnavel in the early spring of 1925. Within the corresponding case conference, it is revealed that the young girl could merely whisper her name, and proceed to answer in short, often monosyllabic, words. A ‘coarse tremor’ in both her arms and also her head were noted to correspond to any attempt made by the patient to move, while she was unable to walk despite being supported on both sides.¹¹⁵

¹¹¹ Case no 253 GB 812 HB13/5/181/21 NHSGGCA.

¹¹² Sacks *Awakenings* p. 12.

¹¹³ Anon ‘The Memorandum on Encephalitis Lethargica’ *The Lancet* June 7, (1924) p. 1163.

¹¹⁴ Anon ‘Economo on Encephalitis Lethargica’ *The Lancet* 218, 5633, Aug 15 (1931) 362-3 p. 362.

¹¹⁵ Case no 253 GB 812 HB13/5/181/21 NHSGGCA.

Within the staff meeting, the stenographer recorded little in the way of a patient narrative. Her general appearance was described as appearing ‘just like an idiot’: she ‘sat with her mouth half open, the saliva drooling from it, her head stooped forward, the neck muscles stiff, her whole appearance drooping – quite expressionless’. Yet, despite this patient’s inability to voice her own narrative, we may infer from the stenographic transcript that an array of therapeutic, technological and medical procedures were used by Gartnavel’s practitioners in their attempts to treat and, most poignantly, to understand what was going on in the mind of such a case.

Firstly, the case conference attests to the array of medicinal measures that had hitherto been used, largely with little success, by the wider medical community. After practitioners such as P. Boveri and C. W. Forsyth had hypothesised that there was an abnormality in the cerebrospinal fluids of encephalitis patients,¹¹⁶ great emphasis was placed upon the further discovery of pathological changes in the nervous system,¹¹⁷ but this failed to produce any affective medicinal treatments. In the staff meeting, Henderson rebutted a suggestion made by his colleague that there could be therapeutic benefits in prescribing an intravenous injection of cerebrospinal fluids, while the injection of salicylate preparations was also seen to provide little long-term effect to patients who had passed through the acute stage of the illness. “What are you doing for her”, asked Dr Knight in the case conference; “Nothing”, replied Henderson, “I don’t know of anything to do”. The rapid onset of illness, the mystery surrounding its transmission,¹¹⁸ the high mortality rate (contemporarily given as between 20 to 50% of those infected),¹¹⁹ and a poor prognosis clearly provoked therapeutic pessimism amongst medical practitioners.¹²⁰

¹¹⁶ C. W. Forsyth ‘The Cerebro-Spinal Fluid in Epidemic Encephalitis’ (originally published in the *Journal of Nervous and Mental Diseases*, October 1920) *The British Journal of Psychiatry* 67 (1921) 238-39 pp. 238-39.

¹¹⁷ Helen S. E. Murray ‘The Histopathology of the Parkinsonian Syndrome Following Encephalitis Lethargica’ *The British Journal of Psychiatry* 74 (1928) 405-409.

¹¹⁸ Anon ‘Encephalitis of Lethargica Type in a Mental Hospital’ *The Lancet* Nov 5, (1966) 1014-15, pp. 1014-15.

¹¹⁹ Anon ‘The Memorandum on Encephalitis Lethargica’ p. 1163. See also Anon ‘Prognosis in Encephalitis Lethargica’ *The Lancet* Jan 29, (1921) p. 246. In which it is stated ‘Of the 541 cases of encephalitis lethargica notified during 1919 from England and Wales, no less than 286 proved fatal - a mortality of 54.6 per cent. A later review of this series resulted in the elimination of a certain number of fatal cases by reason of mistaken diagnosis, but even so the death-rate figure remained at 50 per cent... The fatality is greatest in those over the age of 30’.

¹²⁰ It was recorded in a letter to the Editor of the *Lancet* in 1921 that through the analysis of a collection of case reports, alongside the ‘examination of several old cases’, that ‘in many instances the latter stages of the disease may be very prolonged and the source of much anxiety both to the patient and his medical attendant. Facial and ocular palsies, marked paresis, and sometimes paralysis, of a limb or limbs, and tremors in the parts so affected are constantly mentioned as existing after the patient has resumed, or partially resumed, his normal occupation. In addition, the higher faculties are apt to remain for some time

Following Economo's lead, Henderson noted that those patients who survived the acute stage of illness were often described as resembling a 'burnt-out volcano' or an empty shell. Such therapeutic pessimism was reflected in a paper presented to the Medico-Chirurgical Society in Glasgow by psychologists who had previously examined the girl before her admittance to Gartnavel. By carrying out the Binet Simon test, which had first been developed in 1905 to measure the intelligence of children, the opinion had been formed that there had been a 'great falling off' of both the girl's physical and 'intellectual level'. But for Henderson and his fellow colleagues, careful observation of her behaviour, and of her delayed responses to questions designed to test her memory, orientation and emotional state, revealed that, contrary to the Binet-Simon test results, there was the 'extraordinary retention' of her 'memory and intellectual faculties'. 'One thing, and one alone,' wrote Oliver Sacks in his studies undertaken in the 1960s and 70s of post-encephalitis lethargica patients, 'was (usually) spared amid the ravages of this otherwise engulfing disease: the 'higher faculties' – intelligence, imagination, judgement, and humour. These were exempted for better or worse'.¹²¹

'I did not feel it was a fair comparison', observed Henderson regarding to the psychological test, 'because we all know how difficult it is to carry out a Binet-Simon test on the ordinary child, to get their cooperation, and I think to take a condition like encephalitis lethargica, and to try a Binet-Simon test on a person suffering in that way – it is almost impossible to draw any conclusions'.¹²² Within the corresponding case note records, observations by nurses and psychiatrists demonstrate some of the brief moments when the girl's personality shone through showing an acute awareness of, and engagement with, the world around her. 'She takes quite an interest in the activities of the ward', declared one of Gartnavel's practitioners, 'and from the following incident it will be apparent that her mental life is not at such a low ebb as one would imagine from her appearance':

There is at present in the same ward a very agitated lady who is continually writing to her father and continually making demands that he should be sent for in order to

distinctly impaired, so that loss of memory, defects of speech, mental lethargy, and a general loss of intellectual tone result'. Unknown 'Prognosis in Encephalitis Lethargica' p. 246.

¹²¹ Sacks *Awakenings* p. 20.

¹²² 'Staff Meeting' Case no 253 GB 812 HB13/5/181/21 NHSGGCA p. 3.

take her home. This patient's conduct is very trying to the other ladies in the ward. A day or two ago one of the consultants to the hospital – a gentleman with a beard came into the ward to examine a case. On seeing him enter Miss [Duncan] ... was seen to smile with evident amusement and when the nurse asked her why she smiled she replied "Here's Papa come now." This being a reference to the agitated lady's constant demands for her father.¹²³

A third point which strikes as one reads the case conference transcript is the larger social, economic and familial problems that surrounded such a case. The mother of the child was described by Henderson as 'a widow with a large family ... in poor circumstances' who brought her child to the Out-Patient Department for Psychiatric Cases at the Western Infirmary, Glasgow. After spotting this young girl, Henderson recognised that there was no provision made available to this mother for the care of her child. '[I]t is an appalling state of affairs', he lamented within the staff meeting, 'that a child who has started off well, suddenly inflicted with a dreadful condition such as this, should not be looked after somewhere'. The girl's admittance to Gartnavel, stated Henderson, was due to his intervention. He had put the case before the Directors of Gartnavel and secured her admittance as a voluntary patient without any charge being made to her mother. Unaware of any successful therapeutic treatment, Henderson stated that he simply hoped 'we might be able to get her outside, and look after her and care for her in a way her mother could not care for her at home'.

At the end of 1925 Henderson wrote in his piece for the *Annual Report* about the prevalence of epidemic encephalitis and the problems facing such individuals. 'We constantly see cases of this type', noted Henderson, 'for which there is no adequate provision':

The general hospitals and the fever hospitals deal with these cases practically only in the acute stages, while in the chronic, permanently enfeebled state there is no provision outside of a mental hospital, and a mental hospital is not the proper place for them.¹²⁴

Under Henderson's superintendence, Gartnavel offered a place of shelter. It played a minor, yet significant, role in the care of vulnerable individuals for whom the state denied

¹²³ Case no 253 GB 812 HB13/5/181/21 NHSGGCA.

¹²⁴ D. K. Henderson 'Report of the Physician-Superintendent for the Year 1925' *The One Hundred and Twelfth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) For the Year 1925* (Glasgow: Gartnavel Mental Hospital, 1926) p. 22.

adequate support or provision. '[I]t is a very big social question', concluded Henderson in the staff meeting. Pointing towards the larger social problem posed by economic deprivation, he declared to his staff that: 'It is a different thing for people with money, but for people in poor circumstances it is even more tragic'.¹²⁵

Conclusions

The asylum is the psychiatrist's body, stretched and distended to the dimensions of an establishment, extended to the point that his power is exerted as if every part of the asylum is a part of his own body, controlled by his own nerves... the first reality the patient must encounter, and which is, in a way, the reality through which all the other elements of reality will have to pass, is the psychiatrist's body ... every therapy begins with the sudden appearance of the psychiatrist in person ... This body must impress itself on the patient as reality, or as that through which the reality of every other reality will have to pass; this is the body to which the patient must be subjected.¹²⁶

When reflecting upon the two, somewhat dichotomous components of the staff meeting, made up of the examination or interview, followed by debate and discussion, the thematics that emerge from these meetings are arguably those of power, language and the construction of reality. Staff meeting transcripts, which allow a near unique window into the formation of diagnoses and prognoses, evidence dynamic psychiatry in action, and it is from these records that the mechanics of psychiatric practice may be revealed.

Taking the thematic of power into consideration, its uneven dispersal between senior and junior medical officers becomes clear within staff meeting transcripts, as a hierarchy of knowledge production is revealed. The process, by which ideas and opinions are discursively distributed, digested and used in collaboration with others, becomes transparent, allowing for a history to emerge of psychiatry in the making. Patient agency may likewise be considered in minute detail, for as their actions and volitions are captured within the distinct spatial and discursive contexts of the staff meeting, we may explore how patients negotiated, interacted within or distanced themselves from, clinical encounters.

When we look to the relations of power that flowed between patients and medical officers, this picture increases in complexity. Akin to the Foucauldian analogy of the 'psychiatrist's

¹²⁵ Case no 253 GB 812 HB13/5/181/21 NHSGGCA p. 4.

¹²⁶ Foucault *Psychiatric Power* pp. 181-82.

body' representing the reality to which the patient 'must be subjected', the reality to which Gartnavel's patients were encouraged to conform is that of the clinical environment. This environment is made real by the authority of a medical profession, whose language, whose system of record keeping and whose built environment, is used to impress upon the patient the reality of their illness and their need for hospital treatment. Transcripts allow us to understand precisely how Gartnavel's medical officers, and Meyer himself, used the staff meeting as a platform from which to impress upon the patient, this common sense reality.

Unlike the 19th century asylum doctors portrayed by Foucault, however, it is clear that Gartnavel's medical officers envisaged the use of reason and persuasion, rather than the application of 'laudanum' or 'ether', to correct patients' 'unhealthy' adaptations to the environment.¹²⁷ Rather than create docile bodies that were amenable to psychiatric control, Gartnavel's patients were encouraged to become an active participant in the process of examination and consecutive therapeutic treatments. Rather than directly challenge or denigrate the phenomenological reality of patients' beliefs and experiences, Gartnavel's medical officers endeavoured to contrast patient's 'unhealthy' ways of thinking with a reality that was evident and observable to both parties. The power to construct this shared reality therefore lay between patient and practitioner, relying on both parties to understand the other's perspective, to engage and to empathise with the other's phenomenological experience of the world around them.

Of course, this is not to say that the dispersal of power is equal. We hear within a number of transcriptions that while the patient is present within the examination room, Gartnavel's medical officers spoke *about*, not *to* the patient, treating them as an object of study, rather than a subject with which to engage. The more disordered and seemingly alien the patient's behaviours are, the more they appear to be objectified, the more the 'disease' or the 'reaction-type' becomes the focus of discussion, rather than the patient themselves. It is arguably this inherent tension, between the study of mental illness as an 'individual affair' and the study of mental illness as a biomedical entity, that underlies the philosophies and clinical activities of dynamic psychiatry.¹²⁸

When considering those patients whose presence within the staff meeting was, on occasion, unacknowledged; who became the object of the debates and discussions that

¹²⁷ Ibid p. 181.

¹²⁸ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. viii.

ensued in front of them, transcriptions encourage us to question whether this was a disconcerting process, whether this display of clinical acumen inspired confidence in the patient, or whether it simply went unnoticed? Moreover, with patients placed in front of a panel of consulting staff, we begin to understand how the physical layout of the room, the discursive formalities of the interview, and the less tangible, but distinctly authoritarian atmosphere of the clinical encounter, shaped patient narratives.

My final point, when considering the themes of language, power and reality, are the polarities that exist between voluntary, voluble fee-paying patients such as George Armstrong, who freely discharged himself, and Hannah Duncan, mute, poor and dependent upon the aid, kindness and financial support of others. For patients such as Armstrong, his voluntary admission gave him the power to reject Henderson's advice and treatment. He could direct his own affairs and live within a reality that was in many ways, under his own construction. This degree of freedom is seen by Henderson to be injurious to his own health and to the health and happiness of those around him. It underlines the paradoxical necessity of gaining patients voluntarily, while maintaining the power to override patients' decisions and to impose upon them the psychiatrist's own sense of better judgement. In stark contrast, we see the case of Hannah Duncan. Her inability to communicate and to control her actions, coupled with her relative poverty, means that the reality, to which she must conform, is almost entirely shaped and controlled by others. These two cases, which are both extreme examples of the differing degrees of power held by Gartnavel's patients, from which to shape their own lived reality, reveal some of wider issues that differentiate patient experiences and which shape clinical encounters. Differing diagnoses, differing admission status, differing class, gender and financial backgrounds, subtly shape the clinical encounter, and this is highlighted, in the vivid and evocative transcripts of the staff meeting.

So far analysis has looked to case note records in which the voice of Gartnavel's medical officers predominates over patient narratives. The following chapter looks to readdress this imbalance, by looking towards sources in which the voice of the patient increasingly takes centre stage. Using case note records that preserved further conversations between patients and medical officers, as well as stories, letters and reports written by patients outside of clinical encounters, I explore some of the alternative ways by which patients narrated their own stories and made sense of their life histories, within and outwith Gartnavel.

Figure 15. Letters and pictures taken from patient correspondence. Case notes no 268 GB812 HB13/5/181/36, Case notes no 128 GB812 HB13/5/179/28, Letters GB 812 HB13/11/2. Copyright NHS Greater Glasgow and Clyde Archives. Printed with the kind permission of head archivist Alistair Tough.



CHAPTER SIX

PATIENT NARRATIVES AND THE ARTICULATION OF IDENTITIES, PSYCHES AND SPACES

The illness narrative is a story the patient tells, and significant others retell – to give coherence to the distinctive events and long term course of suffering ... retrospective narratization can readily be shown to distort the actual happenings (the history) of the illness experience, since its *raison d'être* is not fidelity to historical circumstances but rather significance and validity in the creation of a life story.¹

‘Every time a patient enters a practitioner’s office’, wrote George S. Rousseau, ‘a literary experience is about to occur: replete with characters, setting, time, place, language, and a scenario’.² Over the previous two chapters these literary experiences - though recorded in great detail - bind patient narratives to the medical, spatial and administrative frameworks, that made up the case note record. This chapter begins to break away from these contextual confines, to explore records in which authorial agency is held to a greater degree by patients; where patient narratives are recorded not only in examinatory environments, but also in spaces of Gartnavel used for contemplation, self expression and creativity. Inspired by scholars such as Roy Porter, Arthur Kleinman, Kerry Davies and Alan Ingram, I seek to explore the signs, symbols and cultural references that run throughout patient writings and testimonies, so as to understand more clearly how patients framed their responses to illness and to the imposition of a patient identity.

Beginning with case note records in which word association tests and dream analysis were performed, I explore the alternative psychoanalytic devices of analysis through which patient narratives were recorded and analysed by Gartnavel’s medical officers. With word association tests and dream analysis aiming to unveil the unconscious workings of the mind, this chapter first looks to medical officers’ analysis of the unconscious, while exploring patients’ active participation in unveiling this hidden sphere of mental activity. Moving on, this chapter questions how the silent ‘language of the body’ is expressed by patients and interpreted by Gartnavel’s practitioners, before then inquiring how patients and medical officers could give meaning to experiences of mental illness through theological discourses.

¹ Kleinman *The Illness Narratives* pp. 49-51.

² Rousseau *Enlightenment Borders* p. 10.

At this point in the chapter, I turn away from such sources and move to records written by patients themselves, somewhat outside of clinical encounters. Patient stories, letters and creative writings, penned within dormitories, day rooms and occupational departments, make up the primary source materials.³ These documents, retained by Gartnavel's medical officers and stored in case note files and correspondence folders, speak on a variety of subjects. Written from differing authorial perspectives, they are in many ways unique and incomparable, but each one gives expression to an individual patient's sense of self - formulating, resisting or questioning their identities as patients, as mental health sufferers, as members of society. Patients' discursive constructions of self are therefore the focus of the second half of this chapter. As I trace the differing narrative forms and story-telling genres used by patients to give expression to their identity, I question how these alternative narratives, unrestrained by case taking procedures or the question-and-answer format of staff meetings, may provide new ways for scholars to interrogate and to reproduce patient narratives. As well as embedding patient narratives in clinical environments, I endeavour to understand how patient stories interact with and enrich wider historical topics such as war, gender, work and culture.

Voices from within clinical encounters

Psychoanalytic turn

'In this psychological and psychoanalytic age', wrote Henderson in 1921, 'we are realising that mental disorders are not simply characterised by the expression of absurd delusions and hallucinations, or by odd, strange, bizarre conduct':

... but that these disorders are merely symptoms, and are the result of unhealthy or disorderly habits of thought which people have gradually drifted into. The strange conduct, the delusion, the excitement, or what not, is the attempt of the individual to compensate himself for his own personal difficulties, and often the mental disorder is the expression of a wish which has been unfulfilled.⁴

The records that emerged from the anamnesis, the physical and mental examinations and staff meetings provided Gartnavel's medical officers with the raw materials from which to construct a case note record; yet, to get at the *meaning* of a delusion or a hallucination, they needed to press their investigations further into patient life histories, encouraging

³ Henderson 'Report of the Physician-Superintendent for the Year 1921' p 16.

⁴ Ibid.

patients to give detailed accounts of their own story. For psychiatrists such as Kirby, it was reckoned that ‘an effort should be made to investigate as thoroughly as possible the conscious and unconscious wishes and conflicts of the patient’, and to establish their connections to the ‘development of the psychosis’. In alignment with psychoanalytic treatments, Gartnavel’s medical officers strove to give meaning to the ‘strange conduct, the delusion, the excitement, or what not’ that were understood to be symptomatic of mental illness.

Hallucination, for example, was given a largely Freudian resumé by Henderson and Gillespie, as they supposed it to be, in many cases, representative of a ‘wish’ that is ‘disowned by the ego and is repressed into the unconscious’. Once there, they wrote, ‘it assumes independent activity, and forces its way into the conscious by the only methods permitted to it – in disguise’.⁵ With psychoanalysis playing such a leading role in Henderson’s conceptualisation of psychopathology, case note records reveal Gartnavel’s medical officers devoted many hours of conversation to patients for whom the presence of ‘unusual attachments’, ‘infantile interests’, ‘repressed instinctive desires’ and the like were understood to give meaning to the overall symptom picture. Akin to the various talking therapies, these conversations, remarked Kirby, aimed to explore the *consciously* expressed ‘wishes and conflicts of the patient’ which gave rise to hallucination, delusion, and diverse emotional or intellectual reactions. Additionally, however, Gartnavel’s medical officers also wanted to access material that resided ‘beyond the range of [the patient’s] conscious memories’. Kirby suggested that, to access those ideas and emotions which resided in the unconscious mind, techniques associated with the psychoanalytic movement were required; the first of which was ‘Free association’, the second was ‘Hypnosis’ and the third ‘Dream analysis’.⁶

Deriving from the psychoanalytic techniques of Sigmund Freud, Carl Jung and William White, as well as the dynamic psychiatry of August Hoch and Shepherd Franz, Gartnavel’s psychiatrists employed a range of examinatory and therapeutic techniques on a number of choice cases, seeking ‘instincts ... feelings and attitudes’ which were understood to reside in both the conscious and unconscious mind.⁷ Within Gartnavel’s case note records no

⁵ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 91-94.

⁶ Kirby *Guides for History Taking* pp. 78-79.

⁷ Ibid. See also Sigmund Freud *Selected Papers on Dreams* (1914) - *Beyond the Pleasure Principle* (1922) - *The Ego and the Id* (1927), see also William A. White *Outlines of Psychiatry* (1929) and Carl Jung *Studies in Word Association* (1919), all references taken from Henderson and Gillespie *A Text-Book of*

recorded evidence of hypnosis being used on a patient has so far been uncovered, but, as the following cases demonstrate, techniques of free association and dream analysis were employed.

Free association

Tests for association consisted of the patient being given a ‘stimulus word’ and then being ‘instructed to report the first associated idea which comes to mind’.⁸ When defining free association and its role in general psychopathology, Henderson and Gillespie began by stating that ‘association’ was the mental connection of ‘one idea with another or of an emotion or feeling with an idea’.⁹ Once an idea became associated with a certain feeling, they postulated that ‘the revival of the idea ... may revive the feeling’. Thus, wrote Shepherd Franz, when the word ‘fire is given to you it may produce not only an idea of fire but also the idea of “burn” or “match” or a “house burning” or “light”’.¹⁰ The significance of association for the mental examination was laid down by Franz, who claimed that, in certain pathological conditions, ‘abnormal, or rather not normal, reactions’ become associated with distinct stimuli.¹¹ Certain experiences, words, images, and sounds could gain a strong emotional colouring, and these emotions, once revived by a stimulus association, were productive of distinct motor reactions and mental processes.¹² To demonstrate the practical application of this theory, Henderson and Gillespie gave the example of individuals for whom it was theorised that their sexual development had been ‘arrested’ at an ‘intermediate stage (the autoerotic or homosexual)’. If such individuals were accepting of their homosexuality in a ‘matter-of-fact way’, Henderson and Gillespie surmised that ‘no mental disorder results’, but if homosexuality became associated in their mind with the ‘socially induced feeling of guilt’ - and if the individual therefore ‘represses his tendencies from consciousness’ - then this was seen to engender an unhealthy association between thought and emotion.¹³

Psychiatry (1932) pp. 581-83. Sigmund Freud *A General Introduction to Psychoanalysis*, August Hoch ‘Mental Mechanisms in Dementia Praecox’ *Journal Abnormal Psychology* Dec (1910) – reference directly taken from Kirby *Guides for History Taking and Clinical Examination of Psychiatric Cases* pp. 78-79.

⁸ *Ibid* p. 120.

⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 112.

¹⁰ Franz *Handbook of Mental Examination Methods* p. 114.

¹¹ *Ibid* p. 120.

¹² *Ibid* pp. 113-114.

¹³ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 116. This passage may be considered quite forward thinking in its view of homosexuality, as Western psychiatry and psychoanalysis’ relationship to

In the association test, it was observed that patients gave an average response time varying from one second after the stimulus was given to three or four seconds. If an individual made a conscious decision to repress certain thoughts and feelings, then, when an associated stimulus was provided, the patient's response would be given 'only after a much longer interval than others'. For example, Kirby wrote that 'a subject who because of an emotional experience normally has the association "cheek" with the stimulus "red" may report a delayed association like "blood"'.¹⁴ If a significant lapse of time enabled the medical officer to distinguish this response as a secondary idea, it signified the presence of 'hidden associations' or 'submerged ... complexes' which, if discovered, could throw light upon the meaning of a patient's pathological behaviours.¹⁵ As well as revealing repressed ideas and associations, this test could likewise be used to ascertain the general character of associated thoughts that coloured a patient's conscious statements. 'All associations', argued Franz, 'must have worth for the individual even though the experimenter sees no worth in them'. Even the 'neologisms' (made up words) associated with dementia praecox patients were regarded as holding meaning: 'it is only in the logical arrangement of associations in accordance with the ideas of the experimenter', argued Franz, 'that they have no meaning or worth'. Therefore, these tests were designed to draw out the strands of association that gave meaning to patients' strange utterances or bizarre statements.¹⁶

So for example, James Conry, admitted in 1922, was given the following stimulus words [highlighted in bold] to which he gave the following responses:

Ship – imagine seeing a ship sailing

Friendly – two people shaking hands good fellowship anybody speaking to you friendly or anything like that.

Village - my own home – two villages just adjacent.¹⁷

As well as the patient being asked to give a single associated idea, this test was sometimes extended so that the patient was encouraged to give a series of associated ideas. This method encouraged the patient to 'give consecutive associations of ideas just as they came

homosexuality in general - within the first half of the twentieth-century - was, of course, a very fraught one.

¹⁴ Franz *Handbook of Mental Examination Methods* p. 122.

¹⁵ *Ibid* p. 121.

¹⁶ *Ibid* pp. 117-18.

¹⁷ Case no 128 GB812 HB13/5/179/28 NHSGGCA.

into consciousness without any regard to sense, logic or chronological order'.¹⁸ Demonstrated by the continuation of the above quoted association test, the patient's response to such word stimuli as **pier** and **water** drew the conversation towards emotionally laden subjects which occurred most often in his dreams:

To dance – a hall dancing in it. Very fond of dance music particularly waltzes.

To pray – through reading books you find certain things which interests cling to you. [George Reid] ... with whom I was always very friendly regarded prayer as always in the light of asking for help...

He states that a pier often appears in his dreams. His associations for "pier" are "Water – Gourock – disturbed when he heard he was to be transferred to Gourock – when at Gourock he was standing on the edge of the pier one day + a rope from a steamer got entangled with his feet + he was in danger of being drawn into the water ... during the war sentries were posted on the pier at Gourock + he was present when a sentry collapsed full on the point of his bayonet. The sentry's brother was present also + there was a scene – this incident was rather disagreeable to him."¹⁹

Dream analysis

As word association tests were used to tap into the 'dynamic mechanisms' at play in the unconscious mind, it is unsurprising that tests such as the above could merge into the analysis of dreams, which were likewise understood to operate at a semi-conscious level. With dreams being used by Gartnavel's medical officers as a portal into the mental mechanisms of the unconscious mind, the function of dream analysis was to bridge the otherwise unfathomable relations understood to bind repressions and conflicts, set within the unconscious mind, across to the outer projection of such mechanisms through hallucination and delusion. 'Dreams', wrote Henderson and Gillespie:

... are the representations, in the disturbed state of consciousness called sleep, of unconscious mental states ... It is customary to call the dream-content as remembered by the dreamer the "manifest" content, and the unconscious processes which give rise to the latter the "latent" content. This distinction is of considerable importance when applied to psychopathology, for it is held in the Freudian theory that the manifest content is produced from the latent content in the same way that symptoms ("manifest") are produced from unconscious ("latent") factors.²⁰

¹⁸ Franz *Handbook of Mental Examination Methods* p. 126.

¹⁹ Case notes no 128 GB812 HB13/5/179/28 NHSGGCA.

²⁰ Henderson and Gillespie *A Text-Book of Psychiatry* (1932) pp. 474-75.

With the process of dream formation (i.e. the manifest projection of latent content) being so closely aligned with the formation of mental symptoms, (i.e. the manifest formation of latent, unconscious processes), the analysis of both the dream and other (more overt) symptoms such as delusion, obsession and hallucination rested upon similar investigational techniques. Dreams, declared Henderson and Gillespie, were often considered to result from a 'partial failure of repression'. The 'latent' content of the dream, which could originate from unconscious desires and fears, was thought to undergo various processes of transformation before it was 'made palatable to the ego'. Processes of transformation such as 'symbolism', 'displacement' or 'condensation' were understood to produce the 'manifest' content of the dream, and therefore analysis necessitated that the medical officer unearth the symbolic meaning of the pictorial, verbal and emotional contents of a patient's 'manifest' dream and to relate it back to the original 'latent content'. But, unlike Freud, who Henderson and Gillespie considered to over-play the sexual significance of many 'standard symbols', they advised that, to give meaning to such semi-conscious states, 'interpretations have to be very carefully based upon the patient's associations and not on the physician's'.²¹ The following three patient cases (each of which evidences the application of dream analysis) are used to investigate how Henderson and Gillespie's guide for dream analysis, as set out within the *Text-Book*, was practically applied within clinical encounters.

Dreaming and the silent language of the body

The first case to be explored is that of the afore-mentioned Duncan Barrowman, who was admitted in 1925.²² Records provided by his wife, the military authorities, and the patient himself upon admission revealed that, after having served on board several military vessels as an Engineer Lieutenant during the First World War, memories of combat plagued Barrowman's mind in his waking hours and 'terrifying dreams' disrupted his sleep. Upon admission, his memory for certain events during the war seemed poor, while he was very unwilling to speak of others. Hallucinations were particularly predominant in his case, and at times he was seen to wander around the ward 'apparently in a confused state'. Once when addressed, he stated he was 'not confused but terrified' and was 'trying to walk away

²¹ Ibid pp. 432-38.

²² Case notes no 302 GB812 HB13/5/182/12 NHSGGCA.

from his fear'. Feeling compelled to act out his hallucinations, he walked across the ward on tiptoe; this, he revealed, was due to the fear that something underfoot may explode.

The following account, which takes into consideration several interviews conducted between Barrowman and medical officers in the first few weeks after his arrival, demonstrates how his involuntary bodily actions were given further meaning through the steady compilation of the patient's story, retrieved piece by piece through conversation directed towards his memories and dreams. With dreams and hallucinations articulated, upon his arrival to Gartnavel, through compulsive movements of the body rather than through verbal expression, the following section looks to the retrieval of his dreams from the hidden depths of his consciousness, to their painful articulation.

When asked, in one of the very first mental examinations, what he was doing when the War began, he replied: "Wait a bit now I'm feeling confused". After rubbing his brows and looking around 'in a dazed manner', he began to relate how he first sailed in 1914 on an ammunition carrier. His narrative, it was recorded, tended 'to wander off into incoherent mutterings' and so the following story was compiled 'bit by bit' from his diffuse and irregular statements:

From 1914 – end of year – till March 1916 he was in the [name of ship] and was finally blown up in her in the Mediterranean. He was then in the [name of ship] – a trooper – and was voyaging between Dover + Havre. He did not know how long he had been in her but after a while about 9m he thought, he was called up R.N.R. + went into [name of ship] a mine layer. At this point he became very confused + could not say anything for some minutes.²³

Asked about his time spent during the war as a minesweeper on the 'Dover Patrol', Barrowman related how he was engaged in patrolling the coastal waters from Ostend to Dunkirk. 'Any mines they were unable to explode by gunfire had to have their teeth drawn by hand'; this particular job was allotted to the patient.²⁴ His vessel, it was recorded, was 'shelled with much constancy' and they were 'air raided every night'.

²³ Case notes no 302 GB812 HB13/5/182/12 NHSGGCA.

²⁴ Ibid, mental examination conducted early November 1924.

Turning to a subject which Barrowman wished to be kept from the medical record: “Don’t write this down + don’t tell anybody”, he stated. Before recalling that, while on board the ship harboured in Dunkirk:

... the others were all up at the Café Victoria when Mournful Mary went off (this was the hooter for signalling air raids in Dunquerque) and I ran up to the quay to get them back to the ship.²⁵

It was recorded at this point in the examination that ‘[h]e then became confused, emotional and tearful and said he felt very frightened’, but, continuing in the recital of his tale, he told the medical officer ‘how when he landed on the quay a bomb landed near him and at the same moment near by a monitor loosed off her big anti aircraft weapons’. Barrowman recalled he was ‘[p]artly stunned by the concussion and blinded by the flash’, so that ‘he was thrown up in the air and landed on his back and was, he imagines, knocked out for some time’.²⁶

After the armistice of 1918, Barrowman related how he had carried on in his profession, and been married, but that he suffered from periods of tiredness, headaches and sickness, accompanied by feelings described by the medical officer as that of ‘unreality’. The contents of his ‘terrifying dream’, plus the stress of maintaining his employment in the post-war years, ‘combined to render him almost mad’ and he ‘took to drink in an attempt to forget or at any rate to get sleep without his dream’. Barrowman stated he ‘got the wind up very badly, apologised for being so foolish + hoped I didn’t think he was a coward’. Summing up Barrowman’s mental condition, it was recorded that it was ‘one of fear and anxiety’:

He imagines all sorts of war horrors to himself if he has to go out into the ward[,] nerving himself to it makes him quite panic stricken. His dream he says is a vague one but it recurs in a constant form. He is walking along the street in Dunkirk and suddenly becomes filled with a feeling of overpowering anxiety, this becomes worse and he finally feels that he is falling and awakes with a start.²⁷

²⁵ Ibid.

²⁶ An ‘Officer’s Record Card’ accompanied Barrowman’s case note records, which gave details as to how Barrowman had been discharged from service after being caught up in a bombing attack in 1918 at the French port of Dunkirk. A ‘15” gun fired just over his head, same time bomb exploded near him: fainted, removed to base ship, and discharged April /17. Ibid.

²⁷ Ibid.

By enjoining Barrowman's conscious memories of war with reports on the contents of his dreams, Gartnavel's psychiatrists sensitively translated the patient's narrative into a picture of mental mechanisms of fear, guilt and repression, lending psychoanalytic meaning to the patient's hallucinatory experiences. By encouraging Barrowman to speak on subjects that normally repressed and concealed, Gartnavel's practitioners began to determine the specific thoughts and emotions that were to be tackled through talking therapies. Dream analysis could therefore be illuminating for the analyst, but the therapeutic value of such sessions to patients themselves is far more difficult to ascertain from the case note records.

Once again the 'silent language' by which the body spoke of terror and torment, was the more powerful indicator of inner mental state.²⁸ It was recorded that one afternoon, several months after his admission, he was yet again found crying, 'saying that there was a ship sinking and that it was his fault for not putting the mine out of action'. Later, once he recovered his composure, he related how this event had actually happened; that, while he spent a year on board the minesweeper vessel, '[h]e had, in a very heavy sea, been forced to let go of a mine which had been rammed by a small tramp steamer which was in a place she had no business to be'. 'Nothing', wrote the medical officer, 'will make him feel that he is not to blame'.²⁹

Dream diaries and psychoanalytic interpretations

In cases such as the above, the meaning of the dream and its significance to the patient's hallucinatory experiences was, at least on a superficial level, easily correlated with the contents of the patient's consciously voiced narrative.³⁰ But in other cases, medical officers' interpretations of dreams were more contrived, gleaned from a closer adherence to psychoanalytic theory. This contrivance may be seen in the following excerpt taken from the case of a young woman, Annabel Brown, admitted as a voluntary patient in 1930. After writing in her case note records that the patient 'dreams quite a lot', medical officers evidently encouraged the patient to record her dreams as soon as she awoke. A typewritten

²⁸ Michel Foucault writes of the 'silent language by which the mind speaks to itself in the truth proper to it, and the visible articulation in the movements of the body' *Madness and Civilization* (London and New York: Routledge, 2009) p. 94.

²⁹ Case notes no 302 GB812 HB13/5/182/12 NHSGGCA.

³⁰ Henderson explores how the repression of fear could produce hallucinatory experiences in service patients in 'War Psychoses – Dementia Praecox in War Time' *Review of Neurology and Psychiatry* Nov - Dec. (1918) also 'A Review of Service Patients in a Mental Hospital' *American Journal of Psychiatry* 3, 13-58 (1923).

copy of Miss Brown's handwritten accounts of a dream was pinned to her case file, and this document was annotated by a corresponding analysis entitled 'Commentary', constructed by one of Gartnavel's medical officers. A large sample of the typewritten copy is provided below, showing Miss Brown beginning her dream diary by writing:

My dreams seemed to be terribly disconnected and muddled last night, so that I can hardly remember them even now (6.30am)... I dreamt we were all sitting as usual in the long gallery with Sister Nicholson, when I suddenly became ill and felt a sensation of suffocating as if I was going to die; I was very frightened ... I called to Daddy, then Sister seemed to be worried about me and nurse Thomson took my temperature and put me to bed. I next dreamt my old school friends were sitting on the foot of my bed and I was telling them that I had to write out my dreams ... After a little time doctor Paterson came in and asked me if I was going to write them out as it was to do my head good, then he went away saying that if I intended to do it I had only so much time. I dreamt that on the envelope which Dr Paterson really left at my bedside at night before I was asleep was written "(Bar the windows, but not the flowers, No. I. -)"

I can hardly remember what happened after this. There were a lot of parcels on my bed and Miss Keir helped me to clear them away ... after this (there was no connection) I found I was out for a walk with Miss Worthington. We seemed to be locked in a court and could not find our way into the ward

I woke up here at 5.30am & went to sleep again

... I was out for a walk with Sister Kerr. She seemed to understand me, and said she often watched my eyes & saw when I was brooding, then she brought me in and I felt as I must do something, I wanted to feel energetic as if I must explode but nothing happened ... Just before I woke up I dreamt that I was helping nurse Thompson to put some clothes away, then I dreamt that I was with Sister McArthur and Mrs Bennell talking about gym, and we were lifting one another up. Finally Sister said it was time for bed and she began her usual work.

Commentary

Firstly, the sense of suffocation represents failure to sublimate the libido. She solves the problem by adopting the infantile attitude towards life. She calls her Daddy, and is finally put to bed by a nurse. Next she finds herself at the [sic] where she has to face the problem of womanhood again. She is with her school friends and has to deal with sex problems Dr P. tells her she has only a limited time to deal with them. She evidently feels that if she does not solve her problem now, she will never do so. The interesting inscription is in need of further association. It seems to be an indication that she wants to shut out sex but retain her infantile outlook on life. (Flowers symbolise childhood for her.) ?

The parcels on her bed symbolise again the libido, and she has to put things in order very soon. She next goes a walk with Miss Worthington, a very mad patient who is likely to be under institutional treatment for life. At this point she seems to feel that she is in danger of being in here for life. It is significant that she "discusses things"

as if it were by discussing things her salvation would be effected. The other side of the conflict is next represented. Sister Kerr is a very common sense person and always is very severe but kindly with her. She identifies herself with Sister Kerr, who she feels understands her... Again the expression of libido is blocked, and she felt she must explode but nothing happened ... Lastly she was helping the nurse to tidy things up. She is actively engaged in gymnastics with Sister McArthur whom she greatly respects. Sister “began her usual work”. It seems that the outlook is better as she ends up on a more hopeful note.

(Some would see in this first of all a Father fixation, and later a homosexual interest in which she wrestles with the Sister and another patient in the ward.)³¹

With theories of father fixations, homosexual interests, conflicts, repressions, failed sublimation of the libido, and pictorial and verbal symbolism running throughout the medical officer’s dream analysis, such interpretative strategies were evidently used to place the patient’s narrative with a psychoanalytic framework of interpretive theory. The centrality of sex to the analysis is suggestive of the practitioner’s adherence to Freudian psychoanalysis, and yet his interpretation of ‘parcels’ on the patient’s bed as symbols of the ‘libido’ may reflect an influence from the more abstract interpretive methodology of Jung.³² Moreover, in alignment with Jung, the medical officer highlights the purposive role of the dream, for he understood the patient’s identification with the ward sister as an attempt to solve her mental disorder and to reject a patient identity.³³ Behind the use of psychoanalytic terminology, the practitioner’s interpretation of the case is also clearly shaped by his own in-depth knowledge of conditions on the hospital wards. The real life relations that flowed between patients and staff integrally informed his interpretation of the dream, while the symbolic roles attributed to the patient’s father and friends suggest that a thorough acquaintance with the patient’s history further informed his analysis.

Looking beyond the medical officers’ psychoanalytic interpretation, this dream also speaks of the more ordinary daily activities that structured patients’ lives and of the relationships fostered between nurses and patients. There is a sense of the daytime activities being carried out in the long galleries that provided space for indoor exercise, recreation and relaxation, while outdoors we hear of patients strolling in the grounds, in one another’s company. A sense of the communities that could exist within the hospital is evoked in her dream, while her portrayal of the nursing sister’s kindly and empathetic actions towards

³¹ Case no 790 GB812 HB13/5/189/34 NHSGGCA.

³² Henderson and Gillespie *A Text-Book of Psychiatry* (1932) p. 474.

³³ *Ibid* p. 475. ‘Jung’, wrote Henderson and Gillespie ‘emphasised the purposive aspect in dreaming and also in the neuroses – an attempt to solve an immediate problem’.

her tells of the role played by nursing staff, which so often goes unaccounted within case note records.

Proverbial texts and dreams of damnation

One final example where dream analysis was incorporated into the mental examination demonstrates the divergence in techniques used by individual medical officers to give meaning to the psychosis. Meaning in the following case was not gained primarily through the application of Freudian theory, nor could it directly be elicited from the patient's own narrative, but rather from a medical officer's study of biblical scripture. Using the book of Proverbs as an intermediary text, the medical officer produced a secular/psychiatric interpretation of the case; one that reveals much, as to the patient's own narrative choices and theological frameworks of meaning. The case is that of Ernest Barnes, a young farmer's son, admitted to Gartnavel in 1925. In the mental examination, the psychiatrist described the patient as having spoken through a voice that was at times 'almost broken', having 'something of a sob in it', as though he were 'a person ... making a tearful confession'. Licking his lips and moving his tongue as though his mouth were parched, Ernest was observed to show 'considerable ... emotional tension', but when he 'was allowed to develop his story in his own way', it was noted that, 'as if accustomed to his almost continuous narration', the emotion within his voice slowly abated.

The thread of the young man's narrative was noted to be 'very thin', 'diffuse' and 'apt to wander into side issues', but towards the beginning of the interview the conversation covered a profusion of dreams disrupting his sleep, and also proverbial texts through which he gave meaning to his thoughts and imaginings. With reference to one dream, the young man spoke of having envisioned himself back at home on his family farm with one of the farm's servants present. A statement was made by the patient to the effect that 'the son should be above the servant, and not the servant above the son', after which he quoted from the biblical book, 'The Proverbs of Solomon' 10:1: "A wise son maketh a glad father, but a foolish son is the heaviness of his mother." He stated that he was 'rejected of God', denied 'a place' in the world, all because of his former conduct. "I'm a false prophet", he said to the psychiatrist, who "fought" against God and now 'he was not allowed his sleep,

God took it away'.³⁴ During a succession of mental examinations, dominant theological discourse underlay much of Ernest's story, and the practitioner consulted the book of Proverbs, seeking to understand the analogies and ideas interwoven within Ernest's narrative. It was through the analysis of such theological texts that Ernest's 'diffuse' and tangential story was slowly converted from a tale of irredeemable sin to one structured by Gartnavel's psychiatrists, entertaining concepts of 'conflict' and 'introversion', which entered into debate over the 'splitting of his personality'.

To understand how Gartnavel's psychiatrists converted the patient's story into a wider clinical narrative that held diagnostic and prognostic meaning, we can begin with the anamnesis. In the opening pages of the case note record, Ernest was described by his father as an intelligent, family-orientated son who 'made a great confidante of his father and mother and was very much bound up in them' and their family farm. One summer, his father and mother went to America and Ernest was left in charge of the farm 'for about two months'. Case note records report '[h]e is said to have managed this very satisfactorily', but on his father's return Ernest 'said that he had felt the strain very heavily upon him' and a week later he complained of a 'severe depression' which made life 'unbearable'. He gave the origins of his depression as a 'conflict in his mind' over a girl, for he did not know whether he was in love with her. Such feelings reportedly passed and Ernest 'improved considerably', but a year-and-a-half later he once again became 'depressed', and began to talk about a sermon, which 'convinced him that he was condemned for ever and deserted by God on account of his sins'. His sins, he confessed to his father, were that once he had 'behaved himself in an immoral way with a cow', and feared that a farmhand had caught him in the act. He also confessed to having committed 'auto-erotic practices' (masturbation),³⁵ although it was recorded he had given that up.³⁶

³⁴ Case notes no 269 GB 812 HB13/5/181/37 NHSGGCA, referring to 'a long' conversation between patient and practitioner 25th April 1925.

³⁵ Within the psychiatric profession sexual practices such as masturbation were, on the whole, no longer considered to precipitate the physiological causation of mental illness. Within the 1927 edition of Henderson and Gillespie's *Text-Book* it was written that masturbation could play a precipitating role inasmuch as the patient may go on for years 'ruminating over the habit till his feeling of guilt, no longer bearable, comes to be projected, first as ideas of reference, and later as hallucinations or delusions'. 'The guilt-feeling' wrote Henderson and Gillespie, may otherwise lead to the patient experiencing a degree of 'ecstasy in which he feels himself forgiven', men may attempt to expiate themselves through the act of castration, but they were far from the belief, commonly voiced by late nineteenth-century asylum physicians such as Morningside's Thomas Clouston and Gartnavel's former Physician-Superintendent David Yellowless, that an excessive indulgence in masturbation altered the 'appearance, manner and character' of the individual until they fell into a state of 'permanent insanity'. Nonetheless within lay, literary and religious discourses, analogies between masturbation and sin, pollution, and mental and bodily corruption pervaded the cultural consciousness with the early twentieth century. Nineteenth-century psychiatric descriptions of masturbatory insanity were highly physiological in terms, and these

For the duration of Ernest's stay in Gartnavel, which lasted almost six months, the act of bestiality was a central, often occurring theme, which, although never directly spoken about by Ernest, was alluded to again and again throughout his mental examinations. At first he seemed to indicate that the cause of his mental illness stemmed from this single act, but as examinations progressed his medical officer began to unearth a network of 'firmly rooted' ideas, attesting to the complexity and extreme 'difficult[y of the] case'. For instance, when Ernst had first discussed his dream, he had spoken of "a law by which the wicked could be deprived of sleep if they did not cause others to sin". The psychiatrist had at first found this statement 'remarkable' and perplexing, but in searching for the biblical origins of this statement he began to unveil a measure of meaning. From the book of Proverbs, the patient's former statement regarding sin and sleep deprivation makes sense when shown in its original context:

- ¹⁴ Enter not into the path of the wicked,
And go not in the way of evil men.
¹⁵ Avoid it, pass not by it,
Turn from it, and pass away.
¹⁶ For they sleep not, except they have done
mischief;
¹⁷ And their sleep is taken away, unless they
Cause some to fall ...
¹⁸ But the path of the just is as the shining light,
That shineth more and more unto the
Perfect day.
¹⁹ The way of the wicked is as darkness;
They know not at what they stumble.³⁷

Next, when exploring Ernest's claim when recounting his dream that "A wise son maketh a glad father, but a foolish son is the heaviness of his mother", the medical officers directed

images filtered into, and were framed by, wider cultural discourses. Yellowless was considered an expert on masturbatory insanity in the late nineteenth century, writing the entry on the subject in Daniel Hack Tuke's *Dictionary of Psychological Medicine* (1892) 'a highly respected encyclopedic textbook on mental illness' in this period. See Smith and Swann 'Medical Officers and Therapeutics, 1814-1921' p. 64.

³⁶ 'Information from Father' late January 1925. Case notes no. 269 GB 812 HB13/5/181/37 NHSGGCA.

³⁷ 'Proverbs of Solomon' *The Bible, Authorized Version*, ed. John Stirling (Oxford: The University Press, 1956) p. 514. For further reference to scholars who have extensively explored the thematic of religion, which underwrote patient narratives such as Roy Porter, Ann Goldberg and Anne Harrington, see Porter *Mind-Forg'd Manacles*, Anne Goldberg *Sex, Religion and the Making of Modern Madness* (Oxford: Oxford University Press, 1999), Harrington *The Cure Within*.

his conversation towards his earlier ambitions. At Agricultural College, Ernest stated he had taken pride in ‘getting to the bottom of things’ with a ‘a real craving for knowledge’, and that he had gained a ‘1st Class Certificate’. Initially he related how he had no object in life other than to become a farmer, but that he had then found another goal: ‘he desired to be a politician, a Prime Minister, a sort of judge to “advise, to know, to guide, control, shape,” the affairs of men’. Later enquiries revealed that his father had greatly opposed his son taking up a career other than on the family farm, and it was at this point that Ernest recalled having first ‘heard, or felt ... voices in his heart’ telling him to curse his father and mother. “Who so curseth his father or mother”, stated the patient, “his lamp shall be put out in obscure darkness”.

This latter statement, noted the medical officer, was taken from Proverbs XX 20. Having traced the statement to its theological origins, the medical officer postulated that Ernest used this passage to signify how, by defying his parents, he was now ‘without hope’. In Proverbs 4:1-16, the text guides its readers to follow the path of wisdom, and the path of light, goodness and reason; hence, to rebel against a father’s instruction and to turn to the path of the wickedness was to perpetuate their own corruption:

A Father’s Instruction

4 Hear, ye children, the instruction of a father,
And attend to know understanding
2 For I give you good doctrine,
Forsake ye not my law ...
13 Take fast hold of instruction: let her not go
keep her; for she is thy life
14 Enter not into the path of the wicked,
And go not in the way of evil men.
15 Avoid it, pass not by it,
Turn from it, and pass away.
16 For they sleep not, except they have done
mischief;³⁸

Reverting to biblical scripture, Ernest compared himself to Saul, the first biblically recorded King of Israel, who ‘because of his sin had been destroyed by God’.³⁹ Saul,

³⁸ ‘Proverbs of Solomon’ *The Bible* p. 514.

³⁹ In this patient’s case note records an extended note made the medical officer read as follows in relation to Saul: Note

The history of Saul is given in the 1st Book of Samuel ... the portions that seems relevant so far are as follows :

recalled Ernest, had defied God by letting his people take alive the sheep and oxen from their enemy when God had demanded total slaughter. Once again, the significance of the dream - of the farm, the cattle and his fear of eternal downfall - was reinforced with scriptural meaning. He admitted to the medical officer that ‘the fact of Saul’s fall and rejection having to do with cattle had a special significance to him’.

Ernest’s story, when read in the light of the psychiatrist’s own interpretation, evidences a particular response to ambition, temptation, torment and trial. For scholars such as Roy Porter, whose histories of ‘madness’ sometimes look to secular versus Christian interpretations of ‘insanity’, these differential framings are seen to offer rather different outcomes for illness sufferers. On the one hand, declares Porter, secular frameworks defined ‘insanity’ and its incumbent symptoms such as ‘nerves’ or ‘melancholy’ in ‘wholly negative, meaningless’ terms. It ‘betokened utter personal and social nothingness’. Madness, within a Christian framework, however, was a ‘potentially positive phase of spirituality’; it gave meaning, order and a sense of identity to illness sufferers.⁴⁰ A religious framework authenticated Ernest’s belief in his identity as a leader of men, beset by God’s punishments, while it also foretold of the inevitability of his suffering.

Therapeutic spaces, imagined places and identity, within and outwith Gartnavel

Patients’ narratives have been used to illuminate the ‘inner world’ of mental illness, rather than the outer world of the changing experience of being mentally ill. It is these outer experiences - conscious rather than unconscious meanings - ... which have the potential to offer rich new insights into the history of mental illness.⁴¹

The earlier portion (IX and X) tell of the anointing of Saul after he has chosen to be king. The cause of the rejection of Saul is related to the destruction of the Amalekites, and is told in chapter 15. “Thus said the Lord ... Now go and smite Amlek, and utterly destroy all that they have, and spare them not ; but slay both man and woman, infant and suckling, ox and sheep, camel and ass.” Saul defeated the Amalekites, but did not carry out the divine instructions entirely ... Saul came to the prophet Samuel, and Samuel says “What meaneth then this bleating of the sheep in mine ears, and the lowing of oxen which I hear? ... Saul said unto Samuel, I have sinned : for I have transgressed the commandment of the Lord ... I pray thee pardon my sin ... and Samuel said unto Saul, I will not return with thee : for thou hast rejected the word of the Lord, and the Lord hath rejected thee ...

⁴⁰ Porter *Mind Forg’d Manacles* p. 268.

⁴¹ Davies ‘Silent and Censured Travelers’ p. 268.

Among patient case note records there may be found, nestled between case file pages or pinned to folder covers, envelopes containing letters, sometimes artworks, newspaper clippings, stories and poems, all written by Gartnavel's patients (see figure 15). As Allan Beveridge suggests, these patient writings were selectively preserved. Some letters retained within mental hospital case note records are representative of correspondence deemed unsuitable for its intended recipient or because it was seen as 'evidence of mental illness'.⁴² Others were addressed to Henderson and were therefore naturally retained, while artworks, stories and poems were also kept or reproduced, seemingly for the sheer merit of the work. In all such cases these records open up a perspective on hospital life which has long been valued by historians, literary critics, artists and medical professionals alike, histories in which patients creatively gave expression to conscious feelings and thoughts. This section presents a small sample of patient correspondence. Beginning with a letter written by a patient that describes the experience of attending the Occupation Department, and ending with a letter written to Henderson by a patient several years after her discharge, this section moves from a consideration of patient life within the hospital, to one of external environments integral to patient stories and life histories. In doing so, I increasingly apply contextual framework materials to the reading of patient narratives that speak of lives, identities and worlds outside of clinical encounters and institutional grounds. Guided by these stories, I explore how patients' identities were constructed, articulated and experienced as being members of an enclosed institution, but also as individuals with connections to the outer world of work, culture and human relationships.

The 'Occupational Class'

In an institution of this description, when time is apt to hang heavily on one's hands, it is comforting to realise that apart from pacing about the ward or racing one's shadow round the walls of the grounds, it is possible to settle down in one part of the institution without danger of brooding over sorrow, past or to come. It gives one a feeling, on going to the Occupational Class at a regular hour, that even when the real work of the world is in the hands of people blessed with more efficient minds, we are still members of the world, and we still have our little task to do, in our own little corner.⁴³

⁴² On the selective nature of patient letters to be found within asylum records see Beveridge 'Voices of the Mad Patients' pp. 900-901.

⁴³ Anonymous patient letter, 'Correspondence file' containing letters from patients, former patients and relatives of patients, with carbon copies of some replies, GB812 HB13/11/2 NHSGCA.

Writing in the *Annual Report* for the year 1924, Henderson stated that, upon a patient's admittance to the hospital, they were usually in such an 'enfeebled condition of mind and body' that they often felt in 'one way or another' that they had 'failed' to keep 'pace'. Their confidence and 'self-esteem', proposed Henderson, must therefore be restored, not only through the prescription of medicines and by therapeutic talks, but by 'getting the patient to prove that he is still capable of doing something'. Turning back, in many ways, to the early-nineteenth-century principles of moral management, Gartnavel's practitioners looked not only to improve patients' mentalities through their physical wellbeing, but also through strengthening patients' sense of worth and ability. Filed away with a bundle of patient correspondence dating back to the 1920s is a letter, from which the above quote is taken, describing the effect that occupational therapies could have upon patients such as himself.⁴⁴ This patient, whose name does not appear on the letter, used his text to guide his readership away from the 'long and tedious' days spent on a male ward, to the Occupation Pavilion, full of activity, renewed hope and meaningful work for those suffering from 'helplessness and incapability'. Despite the inherent isolation of Gartnavel's patients from the wider social world, his letter highlighted how occupation gave a renewed sense of identity and belonging to patients, for whom their sense of worth had previously deteriorated. His letter continued:

With the erection of the Occupational Department, must have come a message to the patients, that even though discipline, corporality and supervision are essential for their protection, yet those in charge wish to help them to disguise their feelings of helplessness and incapability. To be confined in a ward, with only an occasional stroll or a game of billiards to fall back upon, the days seem long and tedious, but I have found that by starting the day regularly, and by doing things in a business-like manner, according to system, it is possible to make this life as tolerable as that of any business man. Accordingly, ten o'clock finds us at the door of the Occupational

44 In 1923 Henderson drew the attention of the *Annual Report's* readership to the moral treatment of patients in the nineteenth century, drawing parallels between the lost art of moral therapy, and its renewal within Gartnavel in the 20th century. He wrote 'I would like particularly to draw attention to the report published in 1839, in which the following statement is made:- "It was long justly complained of as a radical defect in almost all the Institutions for treatment of the Insane that no proper plan for the employment of lunatics had been adopted. The idea of teaching lunatics to perform any useful handicraft operation would at one time have been treated as altogether chimerical, but by such well-devised occupations as experience has shown to be practicable, this difficulty has been surmounted, and the means have been discovered of affording salutary exercise and amusement to almost every description of the insane, while daily employment is now universally confessed to be one of the most effectual means of promoting their recovery". In the light of these reports it is surprising that more progress has not been made in the occupation of mental patients, but the good work of those early years instead of being continued seems to have been gradually allowed to fade. The development of occupational work is nowadays looked upon as a new means of treatment, whereas it is a method which was perhaps more thoroughly utilized in the middle and early part of the last century that it has been in the course of the last forty or fifty years. Henderson 'Report of the Physician-Superintendent for the Year 1923' p. 22.

Department. This door opens into an ample workshop, given over mainly to the construction of wooden wares, such as stools and book-shelves, though we find a typewriter in agitation from time to time, a fret-saw gnawing parrots or cats from the bottom of a tea-box, or listless fingers weaving threads of wool into a large canvas mesh, to produce ultimately an attractive parti-coloured rug. In the next room we find painting, whether it be in water-colour or oil, to produce Xmas cards or calendars, to be the main pursuit. Passing through this department we enter a spacious hall, which serves as a more refined workroom for both male and female patients, as a music-room, and as a showroom for the combined efforts of the exponents of the many arts and crafts practised here...⁴⁵

For Dorothea Robertson, appointed as Gartnavel's first occupational therapist in 1922,⁴⁶ she reported that, since the building of the new Occupation Department, the new surroundings were 'highly appreciated by the patients, who have shown a keener desire to participate in the work of the class'.⁴⁷ As well as the woodwork, rug-making and painting mentioned in our patient's letter, needlework, basketry, metal working and decorative colour craftwork were offered to patients as forms of occupational therapy; and, from a resident patient population that stood at any one time at around 500 individuals, the number attending the classes was proportionately high.⁴⁸ Totalling on average 98 patients in regular attendance during 1923, many recovering patients went on to help the more acutely ill to attend these classes.⁴⁹

The knock-on effects of the Occupational Department upon the wider hospital environment were noted by Henderson to be highly positive. Patients were considered generally 'quieter' and 'better conducted' on the wards, while members of the occupation class were seen to form distinct social groupings, a number of which went on to organise social events such as dances and Christmas concerts.⁵⁰ Each year Henderson praised the work of the

⁴⁵ Letters from patients, former patients and relatives of patients, with carbon copies of some replies, Correspondence file GB812 HB13/11/2.

⁴⁶ Snedden 'Environment and Architecture' p. 37.

⁴⁷ Robertson 'Occupational Department' pp. 29-30.

⁴⁸ In later years the addition of a fret-machine for woodworking was hoped to enable the production of toys which, 'though [an] extremely simple' craft, would 'provide greater scope for interest and originality,' and as one patient was quoted as having said that "The week I learned china painting has been the happiest I've spent since I have been in hospital'. Robertson 'Occupational Department' pp. 29-30. The total resident patient population was reported in successive editions of the *Annual Report* to be 505 on the 21st February 1923, for the year of 1924 it was 516, 1925 it was 533, 1926 it was 533, 1927 it was 518 and in 1928 this rose slightly to 536.

⁴⁹ Robertson 'Occupational Department' pp. 29-30.

⁵⁰ D. K. Henderson 'Report of the Physician-Superintendent for the Year 1924' *The One Hundred and Eleventh Annual Report of the Glasgow Royal Asylum for the Year 1924* p. 23. GB812 HB13/2/112. See also Hannah Melrose 'Occupational Department' *The One Hundred and Twelfth Annual Report of the Glasgow Royal Asylum for the Year 1925* GB812 HB13/2/113 p. 25.

department in his *Annual Report*, highlighting the success of individual patient cases. The success of the department was also commented upon in the *Annual Report* by the occupation instructresses, who saw first hand the remedial influence of these sessions upon Gartnavel's patients. One of these reports included the case of a 'service' patient whose grumbling attitude and repeated attempts to escape gave way to an interest in craftwork, which 'engrossed him' and 'changed so much his disposition and attitude that he was given parole'. Another patient, it was reported, 'seized' upon a box of watercolours and every afternoon became 'completely absorbed in the production of a series of rectangular shapes'. Indeed:

At the end of the first week the horizon line was suggested in these. "Picture Planes", and the fourth week found these daily series of attempts – to transfer memory pictures to paper – developed to the extent that sea and landscapes, Eastern scenes and architecture were boldly suggested and placed with considerable artistic taste.⁵¹

In 1925 Miss Hannah Melrose took over as occupational therapy instructor, and in the *Annual Report* she wrote that, with the further expansion of the Occupational Department into the Central Hall, the 'splendid light, the sense of space, and the quietness' of the surroundings meant that even the most 'restless and excited patients' were positively influenced by such an environment.⁵² As our patient's letter takes us through the different rooms, segregated into distinct occupational spaces, we hear how this environment contrasted with the solid stonewalls and interior density of Gartnavel's wards, corridors and dormitories. Not only was occupation in itself an enabling activity, but also the very architecture of the building was expressed as instilling a greater sense of freedom and sociability. Shifting from the bustle and noise of the woodworking room to the painting room, and finally to the music hall, this patient's letter juxtaposed the slow, monotonous and enclosed pace of life on the wards with the creative, regular, purposeful and, indeed, freeing environment of the Occupation Pavilion.⁵³

From a final section of our patient's letter, we also get a sense of this space being reserved for a particular type of patient. It is portrayed as a space where the most 'sociable' and 'rational' of patients were permitted to congregate, therefore capturing some of the interior

⁵¹ Melrose 'Occupational Department' (1925) p. 26.

⁵² Melrose 'Occupational Department' (1925) p. 25.

⁵³ For historical and contemporary perspectives on the therapeutic benefits of outdoor spaces in mental health care see Hester Parr 'Mental Health, Nature Work, and Social Inclusion' *Environment and Planning D: Society and Space* 1 (2007) 537-561.

hierarchies and social identities that come about as the result of the spatial segregation of patients:

Disregarding the occupations entirely, the building itself must have a soothing effect, in that there are no locked doors, and there are the walk to and from the class, the change of indoor scenery, the mixing with patients from other wards, and the interest of another patient's work, which all help to prevent a stagnant depression settling on a patient through monotony of occupation and surroundings ... Of course there is other work to be obtained, and there are only a certain number who frequent the class, but it is found that the class is a means of mustering the most sociable, rational and patient of patients together in a society who help one another to forget themselves.

That is the real achievement of the Department.⁵⁴

By losing one's cares in the face of occupation, the Department was portrayed as a space that disconnected patients from their morbid thoughts, bringing them, however loosely, into alignment with the world of work beyond the hospital. It is highly suggestive that, by gaining a purpose, regular routine and set of peers sharing a common interest in the labours of the Department, patients were put on a stronger footing to adapt to the demands of life and work outside of Gartnavel. This letter, while only expressing a single point of view, nonetheless makes us aware of the four-fifths of the patient population not in regular attendance of the occupation class, who by choice or by exclusion were not part of this large, if select group. We are made aware of those patients for whom locked doors, and days spent upon the wards was the norm, and it to the narrative of one such patient that attention now turns.

A tale of 'An Exciting Night'

Filed away in this same correspondence collection was a story entitled *An Exciting Night*, written by a young female patient in 1929.⁵⁵ The patient, a Miss Elizabeth Gordon, was admitted to Gartnavel in 1926 and diagnosed as dementia praecox. Little survives of Miss Gordon's case note records, the admission and discharge registers merely revealing she remained within the asylum until her death in the mid 1950s.⁵⁶ Possessing one of the more severe diagnoses that led to a lifetime confinement, it is likely that the world of Miss

⁵⁴ Letters from patients, former patients and relatives of patients, with carbon copies of some replies, Individual Correspondence GB812 HB13/11/2 NHSGGCA.

⁵⁵ GB812 HB13/11/2 NHSGGCA.

⁵⁶ Asylum Register of Lunatics 1921-1963, GB 812, HB13/6/80 NHSGGCA.

Gordon was confined to the interior of Gartnavel. This interiority is reflected in her writing, as *An Exciting Night* is a story seemingly situated in one of Gartnavel's dormitories. The following excerpt from this story, accompanied by a photograph of the hospital's East House Infirmary Ward, is used to index the alternative perspectives that patient narratives may bring to our understanding of hospital spaces and the individuals inhabiting them.

An Exciting Night

I did not leave my home to come to this benighted spot without leaving behind me also wandering hearts and widely opened eyes among the natives of the village at my sudden and apparently unwarranted transportation. However, always a promoter of peace, except where peace proves ineffectual I decided to spend a few nights in this cold, grey, and if all be known, historic pile. How many unfortunate individuals with pronounced political views or weary claimants to a disputed inheritance must have in past ages been interned here by ambitious rivals or obliging relatives to waste their days in fruitless hopes, with one eye forever on the clock, the other on the door that only brings good tidings to another. – So from early manhood into age time slips away for many Resignation may come at last, but the eyes still retain their keen expectant glare waiting though years have passed for an order of release ... I had not passed many nights here without being reminded that a portion at least of the outer world had not forgotten me. It happened thus. The day had been sultry, with now and then an outbreak of hail showers. Small stones peppering sharply against the window glass. The storm that was brewing had evidently passed. The night was silent though the atmosphere was oppressive. Starting up in the night I heard a distant shout, a wild haloo in chorus. As the shouting increased in volume the galloping of horses could be distinctly heard ... this stirring sound was again broken by a louder yell. Coming from the throats of over a score of men as they hastened on their excited steeds, the old grey building echoed with the sound ... Then there was silence. Inside the old grey building no one stirred. Whether they slept, or lay awake under the bedclothes stiffened with horror to inaction it is difficult to say. Presently there came hurrying footsteps past the window, then the disorderly tramp of men. A loud knocking at the front door, re-newed shouts, loudly repeated demands for admittance made it evident a decisive step must be taken. The building still remained coldly silent ... Roused men are impatient, gradually the cold truth illuminated my mind. It was I who would have to open that door ... Wild thoughts surged through my brain – I pictured myself being dragged from the building in scanty attire, flung across one of the horses, and galloped through the city streets with no more respect to ceremony than if the only road lay across a prairie, the riders yelling all the way. And what after? A voice called out suddenly “D. Better than that!” I did not stop to think. Liberty was sweet ... Getting quietly out of bed I carefully opened the room door, preparatory to rush down the passage to the unknown. But a cold hand drew me back. It was the hand of

the guardian Angel who watched my bed. She locked the door, withdrew the key & put it in her pocket. Ad libetem.⁵⁷



Figure 16. Image showing the East House Infirmary circa the early 1900s. © NHS Greater Glasgow and Clyde Archives. GB 812, HB13/15/25. Printed with the kind permission of head archivist, Alistair Tough.

As fragments of reality and fragments of fiction intermingle in this tale, movement, atmosphere and emotion are instilled into the still image of the hospital interior. With photographs such as figure 16 staged to display a pleasantly fitted room, ornamented with pictures, clocks and flowers, the viewer's eye is drawn to the foreground of the photograph, to the Physician-Superintendent and his nursing staff. The patient is a passive, almost peripheral, component to the picture, as she is the object of medical care within the clinical encounter. But within *An Exciting Night*, objects such as the clock hanging above the door are immediately endowed with alternative symbolic values. A somewhat inauspicious item, half hidden by the light fixture, the clock becomes one of the focal points of the story, as the narrative tells of political prisoners and inheritance claimants

⁵⁷ Letters from patients, former patients and relatives of patients, with carbon copies of some replies, GB812 HB13/11/2. 'Ad libetem' – Latin translation means 'at one's pleasure'.

who, in ages gone by, fruitlessly spent their days “one eye forever on the clock, the other on the door.”⁵⁸

With such objects referencing the indeterminable passage of time, readers begin to forego the frozen perspective of the photographer and enter into an atmosphere filled with sound, sensation, thought and movement. Through her description of the hailstones sharply peppering the hospital windows, passing over to be replaced by darkness and the oppressive atmosphere of a silent night, we engage with a rich, sensually descriptive, account of the hospital interior. Lying at night within a female dormitory, the orientation of her story invites its readers to peer at the ward from beneath her bed sheets, to listen to the silence of the building and the hurrying of the footsteps that passed under the window.

As well as providing an interior account of the asylum building, stories such as these go beyond the hospital walls. For, as her story spoke of a ‘loud knocking at the front door’, the external world comes into focus. While ‘the building remained coldly silent’, impervious to the hammerings of angry men, Gartnavel was forcefully juxtaposed against the aggression and action of the outside world. Such tensions illustrate Kerry Davies’ observation that patient narratives are often invested with “movement and rhythm”; the sharp contrasts between outside life and institutional care producing a wealth of metaphors that convey the stark division of patient identities and experiences inside and outside of the hospital.⁵⁹ Indeed, it is against such a backdrop that the identity of the author herself materialises most vibrantly within the story. By redefining and reinforcing a sense of self that lay outside of the hospital, the tale enabled her to forego her patient identity. Taking on the role of a heroine in distress to be swept up in the arms of her unknown liberators, she immersed herself in a somewhat eroticised tale of fantasy and escapism. Picturing herself ‘dragged from the building in flimsy attire’, flung across a horse and paraded through the streets, this overt portrayal of 1920s cinematic femininity made way for a more subtle expression of confinement, dependency, identity and control. Like the on screen heroines who starred alongside 1920s heart throbs such as Rudolph Valentino and Douglas

⁵⁸ When exploring images of the asylum in the artistic works of the mentally ill, Sander Gilman advises that such representations are not ‘merely a mimetic reflection of the daily world of the insane’ but that such images are tied to the ‘long Western tradition of representing psychopathological states’. Through ‘folk belief, high and low literature, and art’, the asylum became a highly symbolic feature upon Victorian and Edwardian landscapes, and therefore, ‘[n]ot only is madness ... represented in art’, but as Gilman paraphrases Oscar Wilde, it is apparent that art shaped, and continues to shape, ‘our conceptualisation of madness’. Sander Gilman *Disease and Representation, Images of Illness from Madness to AIDS* (London: Cornell University Press, 1988) p. 99.

⁵⁹ Davies ‘A Small Corner that’s for Myself’ p. 308.

Fairbanks, freedom within her story was largely dependent upon the unknown; upon the power and aggression of the masked rider or the desert sheik. Imagining herself to be treated with ‘no more respect to ceremony’ than if she were racing across the vast emptiness of a prairie, liberty was expressed not only in terms of excitement and anticipation, but also with fear and apprehension.

Such narratives, as feminist scholar Nancy Tomes has long argued, may therefore be inspected to reveal the ambiguous, often conflicting experiences of asylum patients, for whom the building could be regarded as a place not only of confinement and control, but also of refuge and respite.⁶⁰ Indeed, when we look to the literary devices employed within the tale, such ambiguity is reflected in the metaphors and meta-narratives chosen to depict the hospital and its inhabitants. In the introduction, her portrayal of the building’s long historical legacy is highly reminiscent of the plot structures and literary forms of Victorian sensation novels.⁶¹ Speaking of illicit incarceration within a Gothic stone structure, her story evokes a sense of horror; but, as her tale moves on, the stylistics of the sensation novel are dropped, and the aesthetics of the building are rendered less formidable when they are contrasted with the speed, anger and potential danger of the marauding horsemen, banging their fists on the door of the hospital’s grand entrance. Finally, with *An Exciting Night* ending so abruptly, the cold hand of the guardian angel drawing the author back, producing the key and locking the door, systems of observation are here dichotomously expressed in terms of care and cold disempowerment.

Through the imagination of such patients, the asylum may therefore be viewed through a multiplicity of narrative stylistics. We may understand how wider narrative genres intersect with patients’ lived experience, producing tales that reflected not only an individual response to hospital care, but also wider ‘social, cultural and medical conceptions of mental illness’ and hospital care.⁶²

With an array of fluctuating perspectives emerging from her story, *An Exciting Night* demonstrates how ‘patients’ tellings are not [necessarily] objects to be [fully] comprehended or mastered, but rather dynamic entities that we approach and engage

⁶⁰ Tomes ‘Feminist Histories of Psychiatry’ p. 359.

⁶¹ For an example of such Victorian ‘sensation novels’ that speak of illicit incarceration, see Wilkie Collins *The Woman in White* (1860; repr. Cambridge: Proquest LLC, 2011).

⁶² Davies ‘Silent and Censured Travelers’ p. 272.

with'.⁶³ By remaining open to the ambiguity of the tale – in alignment with Foucault – what is important in establishing histories of the asylum and its inhabitants is not to portray the institution 'with its regularity, with its rules'. Rather, it is important to approach the interior landscape through the 'imbalances of power', acknowledging the differing points of potential by which individuals chose to assert a degree of agency or conformed to the 'rules which govern them'.⁶⁴ Taking seriously this patient's narrative portrayal of desire, fear, creativity and individual agency, her story recreates the building and its staff as dynamic, ever changing and differentially experienced, yet powerful features of the hospital landscape. Through the analysis of stories such as these, (of which several have so far been found) I concur that they 'may lead us through and beyond' the representation of fact and point towards a 'deeper meaning'.⁶⁵ Such literary experiences, be they concise and well penned or rambling and sporadic, produced by practitioners or by patients, throw new light on the histories once contained within 'this cold, grey and if it be known, historic pile'.

Breaking the boundaries of the mental hospital

Other worlds, other lives, even though so different from our own, have the power of arousing the sympathetic imagination, of awakening an intense and often creative resonance in others.⁶⁶

While samples of patients' literary works shine light on the interior space of Gartnavel, others focus on the world beyond hospital gates. The following patient testimony tells a story of illness and identity embedded within diverse social, geographical and temporal spheres. In the following letter, written to inform Gartnavel's medical officers of his life story, the patient writes about his journey made from the battlefields of the Gallipoli peninsula to his admittance five years later to Gartnavel. Previously a patient at Craiglockart War Hospital and Craiglea Drive Home, Edinburgh, as well as the Montrose and Aberdeen Royal Asylums between 1917 and 1920, a long paper chain of military reports and medical correspondence accompanied this patient to Gartnavel. Interspersing my study of this patient's letter with excerpts taken from accompanying reports and correspondence, these records open up a rich account of a patient's journey from the

⁶³ Johanna Shapiro 'Illness Narratives: Reliability, Authenticity and the Empathic Witness' *Medical Humanities* 37 (2011) 68-72. pp. 70-71.

⁶⁴ Foucault *Psychiatric Power* p. 15.

⁶⁵ Shapiro 'Illness Narratives' p. 70. See also Alessandro Portelli *The Death of Luigi Trastulli and Other Stories. Form and Meaning in Oral History* (Albany: New York Press, 1991) p. 2.

⁶⁶ Sacks *Awakenings* p. xxxviii.

battlefield to the world of peacetime Britain. By fleshing out his story with secondary sources, which speak of the environments in which his tale was set, I examine how, upon his return to Britain, he found himself in a world in which he found it increasingly impossible to adapt.

The Gallipoli identity and the madness of war

At 8am, on 25th April 1915, the 4th Battalion of the Australian and New Zealand forces landed on the beaches of the Gallipoli Peninsula at a place called Gaba Tepe. As part of a 75,000 strong force of soldiers and sailors made up from a Royal Naval Division, the British 29th Division, the French Army Corps, 'Y' Beach force, and the Anzacs (Australian and New Zealand Army Corps), the 4th Battalion Anzac forces embarked on a campaign to capture Constantinople from Turkey and its German allies.⁶⁷ Having climbed down the sides of their battleship into awaiting open boats, the troops reached the beaches under fire from Turkish enemy forces. The first Allied casualties were shot before having stepped from the boats, but for those who waded through the water and rushed upon the shore, their advance was immediately curtailed. Having been told by commanding officers to get off the beach as soon as they reached the enemy shore, the troops found their orders difficult to follow. Having disembarked too far north of the intended landing point, ravines, cliffs and thick, spikey scrub made their advance slow and treacherous.⁶⁸

Fraser Mackenzie, a Scotsman who, after having worked in Australia, enlisted in the 4th Battalion Anzac forces, wrote of the landing while a voluntary patient in Gartnavel.⁶⁹ In a long, and highly detailed account of the personal troubles that stemmed from his war time experiences, he expressed all that he thought significant to his case, to be read by Gartnavel's medical officers.

I have nothing particular on my conscience and could 'sleep on a clothes line' before the war, in fact my motto has been not to do people a bad turn if I could do them a good one, so the trouble is not there. I have certificates for character, conduct, sobriety etc. from 1902 until 1918 in various walks of life. The whole business is a mystery to me and the more I think of it the more mystified I get, so I'll have it alone

⁶⁷ John Laffin *Damn the Dardanelles! The Agony of Gallipoli* (Gloucester: Alan Sutton Publishing, 1989) p. 7.

⁶⁸ Laffin *Damn the Dardanelles! The Agony of Gallipoli* pp. 46-47.

⁶⁹ Medical Card, reveals Mackenzie was a 2nd Lieutenant in the 4th Battalion, engaged in Egypt and Gallipoli from 1914-1915. WO 372/13 The National Archives.

and tackle the dreams. The dream that puts me in a blue funk is connected with the landing at Gallipoli when I was serving with the Australian forces. One of my pals was speaking to me in the boat going ashore and he 'stopped one' with his head and didn't speak again ... I had to break the news of how he died to his people in Sydney when I was sent back wounded, but that is by the way ... On advancing of the hill in straggling or skirmishing order, taking cover as we could, I came to one particular bush something the size of a gorse bush ... and on straightening myself up to look round it, I came face to face with a big Turk. His face and whiskers were dyed green and he had some kind of a wreath made of twigs and leaves on his head. Took all this in before a few seconds had passed and the next thing I know was that he was lunging at me with his bayonet. I had my rifle in my right hand so paired his thrust with my left hand (accidentally smashing my wrist watch in doing so) got hold of my own rifle with both hands and the poor blighter killed himself with the force he was using to try and do for me. We both rolled down the hill a bit but he couldn't struggle much so I pulled out the bayonet, saw red and came to on the top of the hill when we were digging ourselves in.⁷⁰

Digging in and preparing for Turkish counter attacks would become a daily preoccupation for men such as Mackenzie of the 4th Battalion. Clambering up the steep ravines, they were met by wave after wave of charging Turks. Having taken key ridges of land from which to 'dig in' and prepare for further attacks, those few 'crests and hillocks' in a landscape of ravines and tangled valleys would remain in possession of the Allied troops for the next three months.⁷¹ In this time the troops would mow down thousands of Turkish soldiers, who would, in their turn, decimate the Allied troops. Fighting upon such an unforgiving terrain quickly turned into trench warfare. Coming under the attack of enemy grenades, the Anzac's bayonet headed rifles and machine guns provided little defence against the 'cricket ball' style explosives thrown by Turkish soldiers. Appalling casualties ensued during these first few weeks, with shrapnel, explosives and bullets tearing into the bodies of the Allied troops. With the land occupied by the Anzac battalions being less than a square mile, the severely cramped environment resulted in dead and decomposing bodies slowly choking up the trenches and littering the surrounding hillsides.⁷² Disease spread quickly, and with inadequate resources to remove the wounded off the Peninsula, many died from blood loss, dysentery and gangrene before they could reach medical facilities.⁷³ 'Only a soldier who has lived amongst putrefying flesh in the hot sun, with the intermingled stink of excrement and urine, or body odour and cordite', wrote historian

⁷⁰ Excerpt from letter written by Fraser Mackenzie. New case book series males, Vol 25, GB812 HB13/5/147 NHSGGCA.

⁷¹ Laffin *Damn the Dardanelles! The Agony of Gallipoli* p. 54.

⁷² Peter Hart *Gallipoli* (London: Profile Books, 2011) p. 180-81.

⁷³ Laffin *Damn the Dardanelles! The Agony of Gallipoli* p. 152.

John Laffin, 'can know what it was like at the Anzac front'.⁷⁴ Yet, despite the horrors and atrocities experienced by the Anzac troops in the months following the beach landing, Mackenzie wrote that it was his first brutal encounter with the Turk that tortured his nights:

I go through all this at night when this particular dream is on and whilst it is in progress am in mental terror. Have been found by the night attendant moaning and with my face as white as a sheet. The effect of this is to leave me shaky and muddled up next day although in the daytime I look on it as a joke and would not bother myself when I am in full control of my senses but one can't help it when asleep. This is the only dream that leaves me in this condition. There often was dreams but they are only exciting – I yell out, swear and so on, in fact just live them over again, but no other poor devil whom I may have been instrumental in putting to stop comes back to taunt me, probably because I had got used to the game. ... You will understand that this incident occurred in cold blood and, as it was my first taste of killing, probably has much to do with the impression left.⁷⁵

Such events, recurring so vividly in his dreams, demonstrate how an individual's identity is in many ways inherently social and spatial. Upon the Gallipoli peninsula, his survival depended upon his adoption of the Anzac identity - of his coarse, aggressive and fearless demeanour. But back upon British soil, as Mackenzie struggled to reclaim his role as an independent, working man, his letters attested to his inability to adopt a harmonious relationship with his local social environment. Having 'killed a man in cold blood', the recurrence of this nightmarish memory forced him, night after night, to return to the Gallipoli landscape, and therefore to resume the Anzac identity. In his waking hours Mackenzie wrote that he did everything humanly possible to control his thoughts, and to take his mind away from such memories. After the war he spent two years:

... tiring myself out walking, playing games etc., studying at the University and out of it, taking an intelligent interest in the topics of the day ... and finally, when the Officer Department of the Ministry of labour habitually put me off from getting a job for twelve months and nobody could give me a helping hand over the style, managed to get an appointment abroad by my own efforts.⁷⁶

In the day he threw himself into the world of peacetime leisure pursuits, current affairs and training and employment, but at night thoughts of the battlefields returned and the

⁷⁴ Ibid p. 78.

⁷⁵ Excerpt from letter written by Fraser Mackenzie. New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

⁷⁶ Ibid.

‘Reaction’, he wrote, would ‘set in’. Time and again his dreams dragged him back to the killing of the Turk and the foreign landscape of the peninsula. During those nights in which the nightmares returned, the lived, felt reality of his immediate surroundings became enmeshed with memories that affected a deep visceral reaction. Simultaneously inhabiting past and present landscapes, Mackenzie expressed a sense of self very much torn between these temporal and spatial spheres.

Before the Gallipoli campaign ended with Allied defeat in December 1915, Mackenzie was wounded through his left shoulder. This injury was followed several weeks later by a second bullet entering behind his right ear. Transported to Cairo, Egypt, for treatment, he was discharged from duty in 1916 ‘permanently unfit on account of wounds received in active service’. A ‘dull constant pain and an area of tenderness’ was present on the right side of his head near where the bullet had entered, and it was recorded in his medical history that it was about this time that he took to alcohol to “deaden the pain” and “g[e]t some relief”.⁷⁷ As Mackenzie wrote:

The bullet wound in my head is a source of constant trouble, a continuous numbed feeling in the back, which under certain conditions becomes acute. My shoulder is a kind of weather gauge for I can generally tell in the morning without looking out the window if the weather is damp or not. Sleeplessness is the often thing, perhaps not so much complete sleeplessness as lying in a kind of havoc when my dreams are of past events yet I am conscious of anything happening in my immediate vicinity.

After his discharge from the Australian armed forces, he returned to Britain. Before the War he had gained the position of Sub Lieutenant in the Royal Australian Navy, and on account of his previous employment he applied to the Admiralty and was appointed Navigating Officer on a cargo ship bringing oil from Mexico back to Britain. After several trips they were ‘engaged by submarine’ and only managed to escape because of mist looming down off the Irish coast. Subsequently, as his case notes recorded, he became ‘all upset, was tremulous, sleepless “all nerves”’. He resigned his position, then applied to the War Office and gained a Commission in the Royal Engineers (Inland Water Transport). Yet again, after being sent to France he ‘broke down’ and in the autumn of 1917 was sent under the direction of Dr Ivy Mackenzie to Craiglockhart War Hospital for Neurasthenic Officers, Edinburgh. After three months he was transferred to Craiglea, a relatively salubrious addition to the old Edinburgh Royal Asylum, and it was here that Mackenzie’s

⁷⁷ Male and Female Case Notes, Craig House, Record Ref LHB7 C/C WW1 Military, Lothian Health Services Archive, Edinburgh University Library.

case note records began to stress the role of alcohol in shaping his behaviour. While Craiglea records noted Mackenzie's firm resolution that 'he has never been addicted to liquor', on his admittance in mid-December it was noted that he 'smelt strongly of whisky ... made use of much unparliamentary language, was inclined to weep and assumed a threatening and bullying demeanour'.⁷⁸

The cause of his intoxication, reasoned Mackenzie, was due to an incident earlier that month when, after meeting up with old friends in Edinburgh, he 'took more liquor than he could well carry' and was accosted by a man in uniform at Edinburgh train station. Craighouse records state that the man had asked Mackenzie whether he was a patient at Craiglockhart, and, after Mackenzie stated he was, the man in uniform asked "then why don't you wear your blue armlet"? "I know nothing about your blue armlets" replied Mackenzie, "and what the devil do you mean by poking your nose into my affairs"?⁷⁹

"Do you know who you are addressing, sir" said his inquisitor. "No I don't know" said Mr Mackenzie "and I don't care, and if you give me any more of your impudence, I will give you a bump on the nose". Whereupon the Officer, who turned out to be the A. P. M. promptly ordered Mr Mackenzie to be arrested.⁸⁰ He was, subsequently, he says, tried by court-martial at the Castle and severely reprimanded for the offence he had committed. This has rankled in his mind ever since.⁸¹

Having felt he had been unjustly treated, as though 'he were an ordinary, raw subaltern after all his service in the Army and the Navy', Mackenzie related to the Craighouse practitioner that he proceeded to become 'quite reckless', "raised Cain" and delighted in going out into town without permission from Craiglockhart's staff and returning 'the worse for liquor'.

Back in 1915, the Australian forces had become well known for their indifferent, sometimes openly resistant attitude towards authority upon the Gallipoli peninsula. 'Whatever the Australians had been before', writes Laffin, 'in this environment they became rough, hard, foul-mouthed and immensely casual in dress and behaviour. It took a

⁷⁸ Ibid.

⁷⁹ The wearing of a blue armlet signified that the wearer was a convalescent patient. An article on the 'army blues' may be found on the Wellcome Library website on [<http://blog.wellcomelibrary.org/2010/06/the-convalescent-blues-in-frederick-cayley-robinsons-acts-of-mercy/> accessed 26th May 2014].

⁸⁰ 'A.P.M.' is a common army abbreviation for Assistant Provost Marshal. The A.P.M. took charge of a military division's military police.

⁸¹ Male and Female Case Notes, Craig House, Record Ref LHB7 C/C WW1 Military, Lothian Health Services Archive, Edinburgh University Library.

much respected officer to draw a salute at Anzac'.⁸² For Mackenzie, these characteristics offer a direct parallel to his behaviour when taking alcohol, seemingly caught between these two worlds, one of order, authority and peace in Britain, and the other of terror and barbarity elsewhere. Alcohol, it is to be believed, momentarily dulled both worlds from his conscious state. 'At his best', it was noted in his case records, 'he is a very intelligent, interesting and amiable man', but, since he complained that intermittent headaches dulled his concentration and that he spent many 'wretched nights' caught in the terror of his dreams, he repeatedly sought intoxication and, in turn, resumed the Anzac demeanour:

... he returned to Craiglea about 10 o'clock this evening, in a very flustered, excitable, irritable state. He was inclined to be very quarrelsome, spoke very rudely to Dr Robertson, Dr Johnstone and Miss Black, the Matron, kicking the front of his gas fire, slamming the doors, sang snatches of songs, talked in a bullying and threatening manner and blasphemed freely, upsetting the peace and quiet of all the other inmates of the Villa.⁸³

The next two years Mackenzie was a voluntary patient at Montrose, Aberdeen and, finally, at Perth Royal Asylums. His records demonstrate that, while Mackenzie repeatedly endeavoured to find employment and return to his pre-War occupation, the night terrors and subsequent periods of intoxication prevented him from accomplishing this aim. A letter written to Henderson by the Physician-Superintendent of Montrose Asylum relayed the information that Mackenzie 'suffered from vague pains at the back of his head with considerable depression at times, and was much troubled with bad dreams and night terrors when he used to shout, jump out of bed, and find himself standing behind the door more or less terror-stricken'. He suffered from a severe form of alcohol withdrawal, 'practically having D.T's' (delirium tremens) wrote the Physician-Superintendent, which saw him repeatedly return to drink.⁸⁴

Despite this Mackenzie's he spent much of 1920 free from alcohol, commencing a planter's course at the University of Aberdeen and transferring himself to the Royal Asylum Aberdeen. During this time, he concealed the fact that he was a patient in a mental hospital to potential employees, securing an appointment in September as Assistant

⁸² Laffin *Damn the Dardanelles! The Agony of Gallipoli* p. 78.

⁸³ Male and Female Case Notes, Craig House, Record Ref LHB7 C/C WW1 Military, Lothian Health Services Archive, Edinburgh University Library.

⁸⁴ Letter written mid October 1920, addressed to Dr D. K. Henderson, Royal Asylum, Gartnavel, from the Physician-Superintendent of the Royal Asylum, Montrose. Retained in New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

Manager of a rubber plantation near Singapore. Setting sail for the East, the first night of the voyage was spent docked in the French port of Marseilles, and it was here that Mackenzie once again ‘felt frightened and ‘strange,’ thinking “everybody was looking at him”.⁸⁵ Yelling out in the night, such involuntary actions frustrated his efforts to conceal his fear. Scaring a female passenger, he wrote that he took himself away from everyone and slept upon deck. It was by such means of concealment that he endeavoured to ‘carry on’, but, after disembarking from the ship, he took drink and came into conflict with French military authorities. Being detained by the authorities, he missed his ship as it set sail in the morning; and, without money to carry on his journey, he made his way to Paris, London and then to Scotland, where he applied once more for treatment within a mental hospital. ‘With reference to the yelling out at night’, wrote Mackenzie in the letter to Gartnavel’s practitioners:

... you will understand that in this civilised country of ours the majority of people will tell other people with a knowing wink that “there is a fellow suffering from the effects of alcohol but will be all right in a day or two” or if there happens to be a nervous female in the vicinity (as happened aboard the ship going East) she thinks that there is a murder going on and she might be the next victim! Leads to all sorts of complications. What a life!⁸⁶

In the dream state, Mackenzie’s mind and body betrayed those fears and thoughts that drew him back to the theatre of war. That which he had repressed, indeed actively ridiculed during his waking hours, surged with renewed force in his dreams, and these emotions affected not only him but also those who surrounded him; his resultant uncontrollable acts exasperated his social exclusion. No longer able to distance himself from his fears, Mackenzie’s story exemplifies how over-powering fears and delusions may radically alter an individual’s sense of self. Having to hide his involuntary cries of fear on board a ship’s deck or to drink his fears into oblivion, we hear how the boundaries between ‘internal and external realities’, between memory and immediate experience, were disrupted.⁸⁷

On his return to Scotland, Mackenzie went back to the Montrose Asylum where he was advised to try the ‘Murray’ Royal Asylum in Perth, but here Mackenzie came into conflict with a Dr Chambers who wrote that, although he ‘did not spend very much time’ with

⁸⁵ Ibid.

⁸⁶ Excerpt from letter written by Fraser Mackenzie New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

⁸⁷ Hester Parr ‘Delusional Geographies: the Experiential Worlds of People During Madness/Illness’ *Environment and Planning D: Society and Space* (1999) 17 p. 673.

Mackenzie, he should never have been admitted. In Chambers' opinion, Mackenzie was 'within bowing distance of a full-blown Paranoia. His intense egotism and conceit', he reasoned, 'can have no other basis. He is utterly untrustworthy and unreliable: his word is worth nothing'.⁸⁸ When Mackenzie had gone into Perth and pawned his ring and watch so that he could buy drink, he had left a bad impression upon Dr Chambers. 'He turned up the following morning as I expected', wrote Chambers, 'looking a little soiled, but not the least ashamed. Being sorry for him I took him in again but I am glad to be rid of him'.

With Mackenzie being castigated by Dr Chambers as an untrustworthy and unreliable character, we hear in Mackenzie's letter his need to readdress some of these criticisms. Evidently aware that he was being labelled an alcoholic, he was determined to rebuff their conclusions to Gartnavel's medical staff.

Might as well touch on the subject of alcohol en passant. If I thought I was alcoholic I should chuck my hand in right away and not bother any more, but again one cannot ignore facts... I was knocking about the country all this year, Aberdeen, Perth, Glasgow and Liverpool and never touched it until two months ago, and then it was because I felt like giving up the ghost, having lost everything. However next morning in my bedroom I decided to carry on and never touched any more, ... My little experience of men afflicted with that complaint is that they will sell anything or do anything to get money for liquor. I haven't come to that yet.⁸⁹

With Mackenzie's statement going directly against that of Dr Chambers and the diagnosis of delirium tremens by the Superintendent of Montrose, I would argue that the identity of an alcoholic, no matter how clearly identified by his doctors, was unacceptable to Mackenzie. In his letter, we hear a rehearsed narrative, one that Mackenzie repeated in different forms during mental examinations in Gartnavel, and one that he had most likely honed over his years of hospital treatment. It may be justifiable to suggest that, by re-telling his story, he was in some ways crafting his own history and giving substance to a sense of self that he was willing to display to others.

Returning to the subject of war, dreams, alienation and identity, Mackenzie continued:

⁸⁸ Letter written mid October addressed to Dr Henderson, Gartnavel, signed by W. D, Chambers of James Murray's Royal asylum Perth. Retained in New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

⁸⁹ New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

'I dream about various of my pals who have gone West, talk with them and then on waking up find they have really gone. Sounds very silly but it all tends to make up for the joy of life. For instance I had a yarn with my brother who was killed, a night of two ago and asked him if he was in Heaven or Hell and how he liked it. He said there was no Hell for sailors and soldiers as they were there already and that there was another war where he was!

Lately I have been having the same as a year ago, viz. dreaming regularly about all forms of sudden death the result of which 'leaves me cold' sometimes a little sad ... Last night (Saturday) for instance I was back at sea as an officer on board ship. I was keeping the 'dead man's watch' i.e. midnight until 4 ... and in full charge when, knowing that it was against every regulation that ever was framed, I left the bridge and went into my cabin for a box of matches.

In getting back to the bridge I found the captain, who asked me what I meant by leaving the ship to her own devices. I replied that I had only gone below etc. etc. He looked at me in a funny kind of way and told me that I had better stay in my cabin until the vessel arrived at port, that I'd had my day and was no further use to God or man. I just told him that I'd thought that myself for a good while but hoped it wasn't true, and walked off.

With ritual, symbolism and metaphor embedded in his dream, Mackenzie's testimony here demonstrated once more how he fashioned meaning from his imaginings and used them to illustrate the origins of his social alienation.⁹⁰ With his dreams suggesting that even at the point of death the soldier keeps on fighting - is still caught in the theatre of war - his testimony offered an allegorical portrayal of his own inability to escape the soldier's identity and to regain his place within peacetime society. Excluded from his work, shunned from the society of 'nervous female[s]' and looked upon as a drunk, multiple barriers were stacking up against him, depriving him of his former identity.

In the final excerpt of Mackenzie's testimony, he came face-to-face with themes of identity, perception and authenticity, speaking of masking his inner feelings and exuding false joviality:

A man can camouflage a good deal by controlling the muscles of his face into various states, the worst being probably known as a smile, grin on what not but there comes a time when he begins to wonder what it is all for and if there is any useful purpose to be served by doing so? He is told to cast his eyes around and see how many people about him are worse off than he is. Granted, but that argument is all bowls, in fact it is no argument at all, for conversely, he can cast his eyes somewhere else and see how many people are better off than he is. I look at the game of life from

⁹⁰ Ingram *The Madhouse of Language* p. 112.

a fairly dispassionate point of view ... and am philosopher enough to face them and I say there comes a time when the grin has to come off.⁹¹

With his attempts to brave the world defined as an act of bravado, we may perceive this to be the face worn by the Anzac soldier whose careless attitude was merely skin deep. It was recorded in his case notes that, soon after writing these words, he ‘became suddenly very depressed and irritable’, saying that ‘no Dr in this earth will ever do him any good and that his outward happiness during the last three weeks has only been a camouflage’. Caught between a once real, now imagined, world of pain and fear, and his current, real, world from which he was socially excluded, the grin, the false mask of bravado, may now be understood as the flimsiest of shields from behind which he could cower. Through the act of story telling, we see this act being thrown aside, with yet again a different face, and a different presentation of self, coming to the fore.

Writing after discharge

The final example of patient correspondence to be sampled is a letter written by Harriet Paterson after her discharge from Gartnavel. This young woman, whose case has previously been mentioned, was admitted to Gartnavel in November 1924 after being transferred from Princes Terrace Nursing Home. One of the principal difficulties faced before her admission had been an ill-fated love affair. The relationship, strongly opposed by the patient’s family, had been broken off shortly before her admission; and throughout the time spent by the patient in Gartnavel, she complained that she could not bear to return to her family home where she had experienced so much unhappiness. The patient, who had previously been living with her family, and had never had a career or any form of occupation, complained in the staff meeting of her lack of purpose and independence. It is evident from repeated interviews with Henderson that she had formed a plan to gain employment and independence upon her discharge, and two years after she left Gartnavel she wrote the following letter to Henderson (see figure 15):

“ONE OF THE L.M.S. HOTELS”
Highland Hotel
Strathpeffer.
29-4. 28-

⁹¹ Excerpt from letter written by Fraser Mackenzie, New Case Book Series Males, Vol 25, GB812 HB13/5/147 NHSGGCA.

My Dear Dr. Henderson

Enclosed is a picture of “our” Hotel – it is beautifully situated, quite up to-date, and charges moderate - £ 7 – 7s per week inclusive – I am sure Strathpeffer Spa affords just the treatment that would cure your sciatica.

The scenery is wonderful – too grand to be described in words – I have been here a week now, I think that I shall like the work, it will be more interesting of course when we open + our visitors arrive – The manageress is extremely kind and a good “hotel” type of woman. Re- my visit to Dollar, where this man [Jamison] lives, who appears to be very anxious to marry me, I took your advice and after a good deal of thought, I told him that I had been in a mental hospital, etc. I could not bring myself to say asylum, though possibly I ought to have done so. However he was as persistent as ever, but I was equally so and just left the matter on a purely friendly basis. Time I suppose will decide, but the desire to have a home of your own and all that, that means. I know it means big responsibilities too, seems so necessary to me, that I am sure I should be too weak, to stay single all my life, provided of course that a suitable offer came along!! Forgive my writing all this, but I simply cannot discuss these things with my people, and I know you fully understand my position.

Very many thanks for your long continued interest and help.

I am

Sincerely yours⁹²

With correspondence clearly passing between Miss Paterson and Henderson two years after her discharge, this letter suggests that a long-lasting bond of care between patient and practitioner could be maintained, extending beyond the immediate parameters of hospital care. The patient showed a keen desire for Henderson to listen to her story, implying that the therapeutic value of telling one’s story to a medically trained ear had likewise persisted beyond the point of discharge. The fact that she confesses this man’s love for her, while at the same time not asking directly for any advice, perhaps reveals that Henderson’s approach to patient care prompted patients to come to their own conclusions through discussion with the psychiatrist, rather than becoming straightforwardly dependent upon their advice.

In response to this patient’s letter, Henderson did give his own opinion as to how the patient should proceed. After commenting on the improving state of his ‘rheumatic condition’ and the ‘most attractive’ appearance of the hotel, he went on to say that ‘I still maintain my opinion ... that in many respects it would be much better for you to live in single blessedness rather than to take on the responsibilities of married life’. He added:

⁹² Letter written by patient dated 29th April 1928. Case notes no 268 GB 812 HB13/5/181/36 NHSGGCA.

I know that there are chances both ways, but, at the same time, I feel that anyway for the present you would be much better to leave the question of marriage alone. You are young enough yet, and you no doubt will have opportunities, and I think that you should delay considering the possibility for a period of several years.⁹³

Nudging, yet not dictating to, Miss Paterson, as to the direction in life that she should take, Henderson signed off the letter with the remark that he would be 'glad to hear' from the patient 'at a later date'. Further encouraging the patient to retain a relationship with Gartnavel that supported her in leading an independent life, this sign off, it may be envisaged, was just one of the ways whereby Henderson furthered his ambition to integrate mental hospital care with a wider programme of social welfare provision.

Conclusions

In the varied forms of patient narratives hitherto sampled, experiences of mental illness are strongly tied to feeling of exclusion and the loss of confidence and control, while health is framed in terms of friendship, employment and securing a positive social identity. Patient identities and the construction of an affirmative sense of self are tightly aligned to the creation of a story. Patients' verbally expressed interactions with their surroundings, be it the Occupational Pavilion, a nursing sister, a sleeping dormitory or an army officer, may tell something about their sense of self, but arguably they reveal much more about the identity/identities they chose to project to others. Tales which express ambiguity or which evidence conflicting statements may also hint at the instability of those identities.

With the previous two chapters set in spaces of examination, such as Gartnavel's reception hallway, its wards and staff meeting rooms, and this chapter then looking more closely at those other spaces and phenomenological worlds in which mental illness was experienced, these differing parameters effectively mark the distinct temporal, spatial, personal and social environments that combined to form the dynamic case note record. By marking off these constituent elements, these chapters lay bare my own methodological approach to the analysis of Gartnavel's case note records. Initially pulling apart the structure, the languages and the knowledges that constituted the case note record, while highlighting the differing social and clinical environments providing the backdrop to these documents, these materials pave the way for chapter seven, which offers an in-depth analysis of a single, dynamically integrated, patient case note record. By doing so, I go on to explore how a

⁹³ Letter written by Henderson dated 1st May 1928, Case notes no 268 GB 812 HB13/5/181/36 NHSGGCA.

particularly decisive interaction between Henderson and one of his patients shaped the course of Western psychiatric history.

CHAPTER SEVEN
FACES OF LUNACY, THEATRES OF MADNESS
A CASE OF MORAL IMBECILITY

Locating Miss M.B.: medicine, society and the ‘moral imbecile’

... we have people in our midst, semi-insane and semi-responsible, if you like to use such terms, who, in every walk of life ... not only are unable to conform adequately in their personal lives, but may even be responsible for some of the greatest social crimes in history ... it is incumbent not to relegate such people to our psychiatric lumber-rooms, but to discuss them, recognize them ... my main reason for introducing you anew to the study of psychopathic states is because they still remain so unclearly understood and differentiated.

(D.K. Henderson *Psychopathic States* 1939)

The observer is confronted with a convincing mask of sanity ... Examination reveals not merely an ordinary two-dimensional mask but what seems to be a solid and substantial structural image of the sane and rational personality ... the observer finds verbal and facial expressions, tones of voice, and all the other signs we have come to regard as implying conviction and emotion ... Only very slowly ... does the conviction come upon us that, despite these rational processes ... we are dealing with something that suggests a subtly constructed reflex machine which can mimic the human personality perfectly ... no one who examines him in a clinical setting can point out in scientific or objective terms why, or how, he is not real.

(Hervey Cleckley *The Mask of Sanity* 1976)

The essential, phenomenological abnormality of dissocial (asocial, antisocial or psychopathic) personality disorder is primarily one of empathy ... It is this inability to feel for himself the discomfort that others experience as a result of his antisocial activities that appears to be absent in the psychopath. Despite such comprehensive descriptions as that of Cleckley (1941), in *The Mask of Sanity*, ... there are still considerable doubts as to whether this personality type ... should be considered within or outside psychiatry... The concept of *moral derangement* was introduced by Benjamin Rush (1812), and of *moral insanity* by Prichard (1835), who considered this to occur among criminals who showed loss of feeling, of control, and of ethical sense, equivalent to mental disease but at a different level. It is important to stress that not all psychopaths are criminal ... Henderson (1939) described *creative, inadequate* and *aggressive psychopathy*, citing Lawrence of Arabia as an example of a creative psychopath.

(Femi Oyeboade *Sims' Symptoms in the Mind* 2008)

Over the past two centuries, various terms such as moral insanity, moral imbecility, constitutional psychopathic inferiority, psychopathic states, and the sociopathic, antisocial or dissocial disorders of personality have been used in Western psychiatry to describe individuals who, despite outwardly displaying normal, even brilliant, intellectual and conversational abilities, fail to conform to the moral and legal standards of society. They are individuals who, despite punishment or reforming treatments, repeatedly distress and inflict pain on others, seemingly without justification, remorse or adequate provocation. Disputes within and outwith the psychiatric profession abound with respect to such diagnoses, their validity having repeatedly been challenged and contested over the last two centuries;¹ but, precisely because of the ambiguities and somewhat paradoxical nature of such antisocial personalities, their case histories have been instrumental in shaping the history of Western psychiatry in the modern era.²

Indeed, from the publication of Prichard's *Treatise on Insanity* in 1835, to Henderson's highly influential text on *Psychopathic States* in 1939, to Cleckley's seminal publication on *The Mask of Sanity* in 1941 and to present day editions of DSM (Diagnostic and Statistical Manual of Mental Disorders) and ICD (International Classification of Diseases), the social identities of such individuals has been torn between that of the mentally ill and the criminally culpable.³ Often regarded, as Henderson colloquially stated, as 'semi-insane' and 'semi-responsible' for their antisocial behaviour, their diagnosis has lain in liminal psychiatric territory. Grouped by ICD-10 and DSM IV classificatory manuals under *personality disorders*, profound confusion persists as to the aetiology, terminology and treatment that should be applied to such problematic individuals.⁴ Plagued by the spectre of 'co-morbidity', their symptoms often fail to correlate with neat diagnostic categories, while the causation of their disorders is envisaged to lie, not with distinct neurological, biochemical, psychological or hereditary determinants, but, as psychiatrist Theodore Millon argues, with a complex and dynamic dysfunction of the personality's

¹ As David W. Jones remarks, 'It can be argued that the set of problems that are described by the varieties of 'personality disorders' ... have, despite the great controversy about their status and validity, been visible in slightly different guises since at least the beginning of the 19th century when the term 'moral insanity' had some currency' in David W. Jones 'A Psychosocial Understanding of Personality Disorder: The Historical Problem of Moral Insanity' in *Emotion, New Psychosocial Perspectives* eds. Shelley Day Selater et al (Great Britain: Palgrave Macmillan, 2009) p. 212 see also Tony Ward 'Psychopathy and Criminal Responsibility in Historical Perspectives' in *Responsibility and Psychopathy: Interfacing Law, Psychiatry and Philosophy* eds. Luca Malatesti and John Macmillan (Oxford: Oxford University Press, 2010) p. 7.

² R. E. Kendell 'The Distinction between Personality Disorder and Mental Illness' *The British Journal of Psychiatry* (2002) 110-115.

³ Jones 'A Psychosocial Understanding' p. 213.

⁴ Oyeboade Sims 'Symptoms in the Mind' pp. 401-413.

ability to adapt to its social environment.⁵ Stemming, as Femi Oyeboode suggests, from a lack of empathy, from disorders in the emotional sphere of cognition, their behaviour, he argued, may often seem strange, cold and aggressive, or inexplicably emotional, manipulative or senseless. Illness, in many respects, is conceived to exist in the disharmony *between* such individuals and members of their society, a problematic proposition that has led numerous scholars and practising psychiatrists to register the inherent social and moral value judgements, which infuse such a diagnostic construct.⁶

As Millon and Oyeboode contend, such problematics stem not only from the fusion of ethical judgements with diagnostic categories, but also from the abstract notion of personality itself. As DSM and ICD condensed descriptions of the psychopathic personality to an array of symptomatological check lists, the encroachment of neo-Kraepelinian classificatory systems, has, since the mid-twentieth-century, been criticised for offering a ‘two dimensional parody of something we all know to be exceedingly complex’.⁷ To begin to explore an individual personality, Millon argues, is necessarily to unearth an interlocking system of memories, unconscious mechanisms and cognitive processes, and to evaluate how such mechanisms, over time, form ‘enduring patterns of perceiving, relating to, thinking about and [coping with] the environment and oneself’.⁸ Personality traits stem from both biological dispositions and experiential learning, they function upon both a material and phenomenological level; and, therefore, as Oyeboode says, psychiatry must not only observe and ‘explain natural phenomena by causal explanation’, but seek to ‘understand human psychiatric phenomena’ on an empathic level.⁹

For psychiatrists such as Peter Tyrer, whose work on the personality disorders was greatly influenced by Henderson’s own research on the psychopathic states, he suggests that, to

⁵ Such maladaptation is described in ICD-10 as ‘deeply ingrained and enduring behaviour patterns’, which ‘manifest themselves as inflexible responses to a broad range of personal and social situations’. The ways in which such individuals are understood to act is with ‘extreme or significant deviation’ from the ways in which the average person in their given culture ‘perceives, thinks, feels, and particularly relates to others’. The complexity of such a theory is elaborated by Millon when stating that ‘environmental circumstances change such that behaviours and strategies that prove adaptive at one time fail to do so at another’, see Theodore Millon *Personality and Psychopathology: Building a Clinical Science* (New York: John Wiley and Sons, 1996) pp. 6 -15.

⁶ Pilgrim ‘Disordered Personalities and Disordered Concepts’ p. 258. See also Peter Sedgwick, who stated in 1981 that ‘disease is a human invention ... there are no illnesses or diseases in nature’ (quoted in Oyeboode, *Sims’ Symptoms in the Mind* p. 434, who stated that medicine is necessarily value laden.)

⁷ Tyrer ‘Personality Disorder’ p. 81.

⁸ Millon *Personality and Psychopathology* p. 15.

⁹ Oyeboode *Sims’ Symptoms in the Mind* pp. 15-16.

begin to grapple with the intricacies of the human personality, it is firstly to the character formations of ‘novelists and playwrights, rather than psychiatrists [that] the student of personality should turn’. The demands of representation, asserts Tyrer, are best met by those with the ‘empathic ability’ to intertwine the inner, intimate complexities of the antisocial personality with ‘the impact their behaviours have upon others’; and yet, as consecutive issues of DSM and ICD negate this narrative framework, condensing the complexities of personality to a series of check lists and statistical criteria, they have been criticised for failing to establish such an empathic link.¹⁰ Failure has most notably stemmed from the devaluation of the stories, memories and narratives of those diagnosed with personality disorders: indeed, because the diagnostic criteria of DSM states that ‘untruthfulness’ is symptomatic of the antisocial personality, psychiatrists have been discouraged from authenticating the personal narratives of their patients.¹¹ Psychiatrists such as Cleckley described the seeming normalcy of the ‘psychopath’ in the 1940s as an outer façade, and their personalities were compared to that of a reflex machine, which mimicked emotion and faked conviction. The personal narratives of such individuals were hence, regarded with distrust and suspicion by many in the latter half of the 20th century.¹² As the antisocial personality was pushed to the margins of psychiatric practice, relegated to the ‘jungle of forensic psychiatry’, it is arguable that the absence of an empathic framework of analysis has done much to enforce society’s distrust and rejection of such individuals, while the increasing depreciation of patients’ narratives has compounded the psychiatric profession’s inability to understand the personality disorders.¹³

To begin to explore, and indeed to influence the study of, such personality disorders, this therefore demands an array of methodological and theoretical approaches be utilised. However, deep disciplinary rifts carve up their analysis. Within the psychiatric profession, behavioural, phenomenological, intrapsychical and biophysical classificatory systems have been applied in the analysis of the disordered personality, but the profession lacks a synthesised approach.¹⁴ Likewise, such a field of study has proven to be one of the most problematic, not only to the mental health profession, but also to criminologists, psychologists and historians, playwrights, sociologists and anthropologists. A scattering of

¹⁰ Tyrer ‘Personality Disorder’ p. 81.

¹¹ Robert D. Hare, Stephen D. Hart and Timothy J. Harpur ‘Psychopathy and the DSM Criteria for Antisocial Personality Disorder’ *Journal of Abnormal Psychology* 100 (1991) 391-398 p. 391.

¹² Hervey Cleckley *The Mask of Sanity* (London: Henry Kimpton, 1976) p. 368.

¹³ Hare ‘Psychopathy and the DSM Criteria’ p. 392. See also Tyrer ‘Personality Disorder’ p. 81.

¹⁴ Millon *Personality and Psychopathology* p. 48.

disjointed and disconnected studies is strewn across the analytical pathway, and therefore I am torn, unsure how to build upon such unstable foundations.¹⁵ But in recent years, descriptive psychopathologists such as Oyebode have adopted a more empathic approach to the study of such personality disorders. As they have striven to engage with the individual histories of those diagnosed with personality disorders, patients' personal narratives have once again become a valued, indeed central component of the diagnostic and therapeutic process. It is therefore the aim of this chapter to ascertain the value of such stories to the history of psychiatry.¹⁶ Through the analysis of the case note records and correspondence files of a young female patient who was admitted to Gartnavel in 1921, and who was classified as a moral defect/constitutional psychopathic inferior, this chapter questions how such an unstable diagnosis was constructed, negotiated and experienced by both patient and practitioner, rebounding into the redefinition of the diagnosis during the post WWI era.

Miss M.B.

With the patient under consideration having spent over a decade in Gartnavel, from her admittance in 1921 to her discharge in 1933, this chapter reveals a long, detailed account of patient care across Henderson's physician superintendence at Gartnavel. The significance of this patient, however, lies not only with the wealth of archival material available for analysis, but because of the pivotal role she played in the development of Henderson's career. Her case history, which was first published in Henderson and Gillespie's *Text-book* in 1927 under the pseudonym of Miss M.B., was recognised as a case of moral deficiency/constitutional psychopathic inferiority. During the next few years, however, Henderson came to reject such diagnostic terms, so her case was, by the late-1930s, reclassified in subsequent editions of the *Text-book* under the heading of the 'Psychopathic States'. Over the years the contents of her case history morphed ever so slightly, while the diagnostic boundaries of the psychopathic states underwent varying degrees of revision; and yet, from 1927 to the 1962 edition of the *Text-book*, Henderson showcased the following case history as the prime instance from which to demonstrate the extreme complexity and diagnostic uncertainties prevalent in such cases. As the case

¹⁵ A recent attempt by playwrights to express the extreme complexity of the personality disorders is Joe Penhall's *Blue/Orange*. Although the personality disorder presented is more akin to the borderline/schizoid personality type, the play nonetheless reveals the extreme ambivalence expressed by many psychiatrists regarding the validity of such personality types whose symptoms are largely unclear, and who are seen to manipulate, distress and confound their practitioners.

¹⁶ Oyebode *Sims' Symptoms in the Mind* pp. 3-4.

history of Miss M.B. bridged such a transitional period in Henderson's work, an analysis of the changing theoretical frameworks which gave meaning to her case would, alone, provide some interesting insights into the evolution of Henderson's career, and more broadly that of psychiatric thought. But by digging deeper, uncovering the case note records, mental examinations and correspondence files of this patient, which date back to the 1920s, the raw mechanics of such a diagnostic transition begin to be unveiled. Through minutely trawling this patient's certification documents, mental examination records, personal correspondence files and her daily, weekly, monthly, yearly case note reports, I aim to investigate, not only the formation of a diagnosis, but the negotiation and representation of this most elusive of subjects, of personality itself, as it was experienced and effectively constructed within the confines of Gartnavel. Reproduced below, her case history gives an account of mental deficiency/constitutional psychopathic inferiority as initially envisaged by Henderson and Gillespie in 1927, while demonstrating the pivotal role played by this patient's case within their account.

A Text-book of Psychiatry for Students and Practitioners (1927)

By D. K. Henderson and R. D. Gillespie

Chapter XIII

MENTAL DEFECT

UNDER the term "mental defect" we propose to include not only intellectual defect in its various grades, but also emotional and moral defects which have been present from an early age. There is a good deal of doubt regarding the exact delimitation of these groups. The term "mental defect" is generally accepted as denoting intellectual defect existing from birth or from the early years of the individual's life. The difficulties arise when it is attempted to denote what is meant by emotional and especially "moral" defect. "Moral" defect is usually applied to those cases in which antisocial conduct has existed from an early age. It is now generally admitted that, as distinct from intellectual and emotional abnormality, moral deficiency cannot be inborn. Moral sentiments are in all cases acquired. Individuals who display moral deficiency have suffered from some antecedent abnormality, intellectual or emotional. This antecedent abnormality may be inborn, or may be acquired from the environment through infection ... or through faulty training... For "emotional instability" and "moral deficiency" or "moral imbecility" as it has unfortunately been called, we shall use the wider term "constitutional psychopathic inferiority"...

Emotional defect states (Constitutional Psychopathic Inferiority)

Under this heading we include persons who have been from childhood or early youth habitually abnormal in their emotional reaction and in their general behaviour, but

who do not reach, except perhaps episodically, a degree of abnormality amounting to certifiable insanity, and who show no demonstrable intellectual defect ... it is usual to place [such individuals] in the group of constitutional psychopaths. The justification for this is twofold - first, he is recognisably abnormal, and required classification for scientific purposes, although the abnormality has not yet led to mental disorder in the usual sense; and second, there is the practical reason that the possession of such a personality is apt to involve the individual in antisocial conduct. ... There remain a few cases in whom moral sentiments do not seem to have developed, and who nevertheless do not suffer from other demonstrable defect. To this limited group the term "moral imbecility" is applied. It seems probable that the close psychological investigation of each individual case of this type will enable the group of so-called "moral imbeciles" to be still further narrowed, or even to be abolished altogether.

For example, in a group comprising 1600 delinquents and 1200 intellectually defectives, 116 had been diagnosed "moral imbeciles". On examining these 116, Burt found that without exception they were either intellectually or temperamentally (emotionally) defective ... Burt therefore concluded that the term "moral imbecile" should be dropped, and the term "temperamentally defective" substituted ... The creation of the subgroup, however, of the emotionally "weak" does not solve the difficulty of the morally defective. There are certainly a few cases in whom the emotions are stable, but perverted in their application. In them also certain emotions or emotional complexes seem to be lacking, especially emotional complexes normally affecting social relationships, such as shame and tenderness. The following is an example of this kind:

CASE 58. – M.B., 24 years old, single, admitted on May 4 1921. For a long number of years this patient had been creating a great deal of difficulty at home, so that her brothers and sisters felt that their mother's life was not safe. It was stated "Her vindictiveness is so extreme that she is capable of anything, while, at the same time, she is so plausible and cunning that she is able to impress all strangers that she is a persecuted saint condemned to live in a family of criminals and savages" A few instances of her conduct are sufficient to describe the case. One of her brothers arrived home on leave from France to visit his father who was dying. She refused to sit by her father when he was ill, to prepare food for him, or to relieve those who had been constantly with him night and day. On the contrary, she jeered at the constant "morbid atmosphere" of the sickroom. The family tried to induce their mother to have a nurse in the house, but she refused to do this lest a stranger should talk outside about her daughter's conduct. She terrorised the home for years, and drove more than one of her sisters away from home by her threats and her violence. On another occasion when her brother came from France, she did not speak to him during the whole time he was in the house. She sat at meals with her face turned away from him, and when he left to return to the front he had to search her out to say good-bye, and his farewell did not meet with any response. Her mother had to sleep at night with her bedroom door locked for fear her daughter's violence, and she had also to lock her door by day in order to guard against thefts. The patient for weeks on end

would not speak to any member of the family, except to demand money or clothing. It was also stated that one of her brothers, who was an apprentice engineer, had to stand over the water which he had heated to have his wash, because if he relaxed his vigilance the patient would take the warm water and pour it down the sink. One day in mid-winter she threw a bucket of cold water and deluged his hens, which were his hobby, “just to see what he would do”. Frequently she told her mother that she “would make her suffer”. On one occasion she walked through the house and crumbled every gas mantle into dust. She lit all the gas jets of the gas stove, and put over them every pot, pan and kettle the stove would hold, and then slipped quietly out of the house. Her habit was to rise any time from 11.30 to 2pm to cook a meal for herself, and then to leave the house without a word to any one. “What she does, where she goes, and who her friends are, none of us are quite sure.” Indian ornaments, sent home by a sister, disappeared, and some Greek metal-ware which was also in the house disappeared and was discovered hidden in the commode in the patient’s bedroom, awaiting a chance to be smuggled out of the house. A brother came home unexpectedly, and found his sister arguing with a rag-woman for the sale of his boots – his second pair.

On account of the difficulties of management, she was certified as being of unsound mind, and was admitted to hospital. During her stay in hospital she has been unreliable in every way. There have been times when she has been better controlled and better behaved, but sooner or later she gets into difficulty again. When found fault with, or criticised, or restrained in any way, she has outbursts of great passion, during which it is almost impossible to control her. She is sulky, spiteful and destructive, making life difficult for the other patients, and even striking those who are most helpless.¹⁷

In the chapter on ‘Mental Deficiency’ that appeared in Henderson and Gillespie’s 1927 *Text-book*, ‘moral deficiency’ was ruefully presented as a stigmatising and medically limited diagnostic term clinging to the vocabulary of the Victorian era. As the case history of Miss M.B. was placed within such an unstable diagnostic category, we engage with a patient identity that was in its very nature fractured, posited as it was within such liminal psychiatric territory. During a period when psychiatrists were challenging the ontological ground of such a diagnostic tool, Henderson and Gillespie’s emphasis on the use of patient case notes to ‘further narrow’, even ‘abolish’, such a category demonstrates how the power of the psychiatric profession to turn away from the theoretical constraints of the nineteenth-century lay, at least partially, in providing new ways of ‘reading’ patient histories and interpreting their behaviour.¹⁸ The following section will briefly sketch the

¹⁷ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) pp. 371-377.

¹⁸ For example, within the 1917 *Lancet* article on ‘The Moral Imbecile’, the author supposed it to be clear that ‘it is the defective born in surroundings of poverty and moral danger who become criminals’. The moral imbecile was understood to have the same desires as the average person, but minus the ‘capacity for inhibition and for realising the wrongness or the consequences of evil-doing ... [thus] his downfall

historical backdrop against which M.B.'s case history was set, before returning to the 1920s, and the vying diagnostic models and theoretical frameworks clustering about Miss M.B.'s case history.

From moral insanity to constitutional psychopathic inferiority – a historical digression

The origins of the term ... although it has had its many synonyms, is not buried too deeply in the dim and distant past. It has become traditional to award priority of comprehensive description to an English physician, Dr. J. C. Prichard ... who in 1835, under the title of moral insanity and moral imbecility, drew attention to certain states which were characterised by a disorder of the affects and feelings in contradistinction to understanding and intellect. The term “moral insanity” gradually passed into disuse, but moral imbecility attained such a degree of popularity that it came to be defined and incorporated into the Mental Deficiency Act of 1913; in the subsequent Act of 1927 it was changed to “moral defective” and it is still in current usage. It is an obvious misnomer, it should be expunged from any subsequent classification, but it can with considerable justification be regarded as the forerunner of psychopathic states as we know them today.¹⁹

History has often given preference to the English anthropologist and physician James Cowles Prichard for first coining the diagnostic term of moral insanity in 1835. Used to denote a class of individuals who, despite the possession of ‘normal’, sometimes brilliant intellectual abilities, were morally depraved, and whose feelings and affections deviated from a supposedly natural state of mind, Prichard described such individuals as being incapable of conducting themselves with ‘decency or propriety in the business of life’.²⁰ Prichard’s definition was a radical proposition in the early-nineteenth-century. At a time when lunacy was conceptualised as the loss of reason, as a disorder of intellect, this meant that, for lunacy to occur in individuals of sound intellect, the mind had to be reconceptualised.²¹ Only once the brain was theorised as being made up of intellectual and moral functional sections of the brain, operating independently from one another, could

becomes natural and easy’. Poverty, rather than an innate propensity to commit immoral acts, was the largest factor noted by this article to cause the ‘total failure’ of the moral imbecile, ‘with money’, concluded the article ‘he could have been sheltered and, possibly, much improved’ Anon ‘The Moral Imbecile’ *The Lancet* March 24, (1917) pp. 459-60.

¹⁹ Henderson *Psychopathic States* p. 11.

²⁰ James Cowles Prichard *A Treatise on Insanity and Other Disorders of the Mind* (London: Sherwood, Gilbert and Piper, 1835) p. 6.

²¹ Aubrey Lewis ‘Psychopathic Personality: a Most Elusive Category’ *Psychological Medicine* 4 (1974) p. 133.

moral imbecility be conceptualised as an illness, signifying a diseased or degenerate brain. Thus, it was not until the mid-nineteenth-century that this revised model became widely accepted, with medical practitioners such as J. Kitching actively promoting such a division of the mind.²² As pre-Darwinian evolutionary theories arose during the second half of the century, the emergent moral insanity diagnosis became enmeshed with the determinist theories of degeneracy proposed by the French physician, Benedict Morel. In such an ideological framework, distinctions were being drawn between acquired and hereditarily determined forms of moral insanity, with British psychiatrists such as Henry Maudsley defining moral insanity as a congenitally determined, inborn and incurable form of disease.²³ Imbued with moralistic overtones, the wilful committal of sin in one generation was theorised to produce nervousness, eccentricity, criminality or sexual perversity in the next. If unchecked, degeneration theorists argued that breeding would produce ‘insanity in the third, idiocy in the fourth and extinction’ by the fifth.²⁴ With the so-called morally insane being considered a ‘diseased element’, a dangerous, hereditarily contaminated class, Maudsley proposed that they ‘must either be got rid of out of the social organisation or be sequestered and made harmless in it’.²⁵

By the end of the nineteenth-century, moral imbecility was being more closely aligned to notions of criminal atavism by physicians such as Havelock Ellis, while for asylum practitioners such as Thomas Clouston, such individuals were described as ‘the bane and disgrace of their families ... the skeleton in the closets of their relations [for whom] nothing can be made ... of them morally’. Such conclusions were highly condemnatory and the outlook for recovery was bleak. Few treatments, stated Clouston, appeared to make any lasting impact upon individuals who instinctively ‘prefer lies to truth, immorality to morality’.²⁶

²² In prominent publications such as the *British Medical Journal*, as he concurred that ‘All those powers of the mind by which we maintain our position as rational creatures... Are intellectual powers’ but that ‘we have other powers...designated by the term ‘moral and instinctive faculties’...’ that ‘preside over the regulation of our conduct towards others and determine our sentiments towards others’. J. Kitching ‘Lecture on Moral Insanity’ *British Medical Journal* (1857a) p. 336 quoted in Heidi Rimke ‘From Sinners to Degenerates: The Medicalization of Morality’ *History of the Human Sciences* 15 (2002) p. 71.

²³ Henry Maudsley *Responsibility in Mental Disease* (London: King, 1874) quoted in Aubrey Lewis ‘Psychopathic personality’ p. 134.

²⁴ Eric T. Carlson and Norman Dain ‘The Meaning of Moral Insanity’ *Bulletin of the History of Medicine* 36 (1962) p. 138. See also Nicole Rafter ‘The Unrepentant Horse-Slasher: Moral Insanity and the Origins of Criminological Thought’ *Criminology* 42 (2006) 979-1008 p. 998.

²⁵ Lewis ‘Psychopathic Personality’ p. 135.

²⁶ Thomas S. Clouston *Clinical Lectures on Mental Diseases* (London: J & A. Churchill, 1898) p. 373.

On the continent, however, concepts of moral insanity were developing in differing directions, for the German psychiatrist Ludwig Koch was, by the 1890s, rejecting the moralistic overtones of degeneracy theory by reclassifying the morally insane as psychopathic inferiors. By dividing the psychopathic inferiorities into distinct subgroups, Koch distinguished those with highly sensitive, tender and impressionable personalities from those who displayed intense egotism and outbreaks of unmitigated fury or irritability. Criticising the determinism of degeneracy theory, Koch emphasised that in successive generations the offspring of the psychopathic inferior could emerge unscathed from congenital deformity; and so by the early decades of the twentieth century the classification of constitutional psychopathic inferiority superseded moral insanity in Germany and North America.²⁷

For Adolf Meyer and Charles Macfie Campbell, Koch's rejection of the moral stigmata attached to such a diagnosis was upheld. The antisocial conduct of such individuals came to be recognised as originating, not from an innate moral defect, but from a 'psychopathic make up' of personality, from an 'increased impressionability ... and sensibility in the emotional sphere'. By the 1910s, the psychobiological formulation of psychopathic inferiority postulated that it was their failure to adapt to the demands of society that stirred within them 'uncontrollable and unjustifiable impulses, unreasonable depression, or unreasoning love or hatred'.²⁸ Despite such developments in the United States, by the turn of the century Emile Kraepelin was ever more closely describing such individuals in terms of the born criminal, with many being regarded as 'shiftless', 'morbid liars and swindlers', 'antisocial and troublemaking types'.²⁹ The British medical profession likewise clung to such stigmatising notions, with the term 'moral imbecility' commonly used to denote this class of individuals. For British eugenicists such as Eugene Talbot, notions of moral imbecility were wedded firmly to degeneracy theory. The moral imbecile was described as an individual who, despite often possessing intellectual abilities marking them out as skilled lawyers, artists or mathematicians, were characteristically marred by a 'permanent

²⁷ Philip Gudmann 'Julius Ludwig Koch (1841-1908) Christian, Philosopher and Psychiatrist' *History of Psychiatry* 19, 2, (2008) p. 210.

²⁸ Adolf Meyer 'Unpublished working notes' (1915) XII/1 Folder 59, AMC see also Charles Macfie Campbell 'The Role of the Psychiatric Dispensary: A Review of the First Year's Work of the Dispensary of the Phipps Psychiatric Clinic' *American Journal of Insanity* Vol LXXI Jan (1915) No. 3 pp. 452, 454. Meyer went on to influence a great many psychiatrists working within North America such as C.P. Obendorf and H. W. Wright whom Henderson stated 'made laudable efforts to effect clearer clinical differentiations' of the constitutional inferior, Henderson *Psychopathic States* p. 23.

²⁹ Emil Kraepelin *Lectures on Clinical Psychiatry* ed. Thomas Johnstone (New York: William Wood and Co, 1904) pp. 289-92.

undercurrent of perverted mental action ... running like an unbroken thread throughout his whole mental life'. Unlike the more pronounced, physically and intellectually stigmatised cases classified as forms as mental defect, such as the 'microcephalic idiot', 'durencephalic monster', 'cretin' or 'mongoloid', the moral imbecile was recognised as lacking the scars, deformities or the irregular speech patterns which may have alerted others to their mental defect. The seeming normality, even brilliance of the moral imbecile, Talbot argued, therefore made them a most dangerous, socially threatening group.³⁰

Once the 1913 *Mental Deficiency Act* had been implemented, 'moral imbecility' had become the most widely recognised diagnostic term for such problematic patients in Britain, and was legally constituted, alongside more overt forms of intellectual and emotional deficiency, as a form of mental deficiency.³¹ The 'moral imbecile' was defined by the *Act* as a person who 'from an early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect'. The *Act* remained in place well into the 1920s, but, as the published case history of Miss M.B. demonstrates, medical practitioners regarded this legal classification with contention.

Disconcertion and disorder between legal and medical debate

The instability of the diagnostic category, as expressed by Henderson and Gillespie, reflected contemporary debate among wider medical and legal communities. The author of an article from the *Lancet* in 1917 recounted that a judge, presiding over the case of a moral imbecile, had declared to a fellow member of the court that "she might be a moral imbecile" but was also an "ingenious, clever thief" and therefore deserving of a penal sentence rather than certification.³² Likewise within the medical profession, many doctors 'either did not understand the definition of moral imbecility given in the *Act* or they refused to use it altogether'.³³ An article published in *The British Medical Journal* in 1914 argued that, despite a number of individuals having been diagnosed as moral imbeciles

³⁰ Eugine S. Talbot *Degeneracy, its Causes, Signs and Results* (London: Walter Scott Ltd, 1898) pp. 315, 325.

³¹ *Ibid.*

³² Anon 'The Moral Imbecile' pp. 459-460.

³³ Stephen Watson 'Malingers, the 'Weakminded' Criminal and the 'Moral Imbecile': How the English Prison Medical Officer Became an Expert in Mental Deficiency, 1880- 1930' in *Legal Medicine in History* ed. Michael Clark and Catherine Crawford (Cambridge: Cambridge University Press, 1994) p. 234. See also Lewis 'Psychopathic Personality' p. 137.

who were neither violent or dangerous to the public, but rather just ‘morally oblique’, no adequate institutional provision had been made for their care and treatment. Recognised as belonging neither to prison or asylum, the author was dismayed to find that, as ‘[t]he local authorities have not yet had time to provide institutions even for the more usual types of defective, ... it is hardly likely that for the present they will, either separately or in conjunction, provide an institution really appropriate to such a small and special category’.³⁴

As the problematic ramifications of the *Act* persisted into the 1920s, professional unrest provoked substantial debate into the definition and diagnosis of moral imbecility. This may be demonstrated in records of the meeting of the Education and Medical Sections of the British Psychological Society in 1926, when Cyril Burt, alongside F.C Shruballs, A.F. Tredgold, M. Hamblin Smith and W. Rees Thomas, presented papers debating ‘The Definition and Diagnosis of Moral Imbecility’. The findings of this symposium clearly influenced Henderson’s formulation of the moral imbecility diagnosis, for the *Text-Book* chapter on ‘Moral Deficiency’ quoted directly from the paper given by the psychologist Burt, and the symposium’s proceedings therefore provide a snapshot of the wider medical, legal and social debates in which Miss M.B.’s case history was tentatively placed. The opening symposium paper began the discussion with the declaration that:

Of the four classes of Mental Defect which are defined in the Mental Deficiency Act of 1913, there is none which has given rise to so much discussion, or about which such widely divergent views are current, as that of Moral Imbecility. On the one hand, there are persons who regard almost every individual guilty of persistent wrongdoings as a Moral Imbecile. On the other hand, there are those who deny the very existence of such a condition.³⁵

The origins of such ambivalence, argued Burt, stemmed back to the legacy of Victorian medical doctrine. Profound divergence of opinion over the very notion of morality itself was, for Burt, one of the main concerns for medical and legal professionals. Henderson concurred in the *Text-Book* chapter on ‘Mental Deficiency’:

³⁴ Anon ‘Moral Imbecility and the Mental Deficiency Act’ *The British Medical Journal* June (1914) p. 1316.

³⁵ A. F. Tredgold ‘The Definition and Diagnosis of Moral Imbecility (I)’ *British Journal of Medical Psychology* VI 1 (1926) 1-9 p. 1.

The difficulties arise when it is attempted to denote what is meant by ... “moral” defect ... It is now generally admitted that, as distinct from intellectual and emotional abnormality[,] ... Moral sentiments are in all cases acquired.

Undermining the ideological roots of the ‘unfortunately’ named moral imbecility diagnosis was, for Burt and Henderson alike, the first of many steps taken as they endeavoured to eradicate the diagnostic category in its entirety.

During the early nineteenth-century, Burt stated that the ‘moral sense was ... depicted as a kind of inherited conscience’, which was objective, immediate and, like the senses of sight or sound, enabled individuals to appreciate what was ‘beautiful or what is good’.³⁶ Maudsley was identified by Burt as having promulgated the concept of an innate moral sense located in some ‘quasi-phrenological organ’ in the ‘frontal lobes’ of the brain; and that, “[j]ust as there are persons who cannot distinguish certain colours”, Maudsley was quoted as having written, “there are some who are congenitally deprived of the moral sense”.³⁷ The notion of a single centre of the brain controlling humans’ moral sense, continued Burt, was a fallacious proposition of the Victorian period, and yet, for late-nineteenth century asylum physicians such as Clouston, the notion of moral insanity remained wedded to such materialist theories.³⁸ To rid psychiatry of the moralistic overtones of the Victorian era, both Burt and Henderson argued that diagnosis should be reconceptualised in terms of intellectual or emotional, rather than moral, deficiency. Henderson deduced that ‘individuals who display moral deficiency have suffered from some antecedent abnormality, intellectual or emotional’, and so a clear division between the nineteenth and early-twentieth century psychiatry was beginning to be made.

As another symposium speaker, F. C. Shruballs, concluded, the purpose of the 1913 *Act* was ‘to meet the public demand for dealing with certain persons who are a danger or a nuisance to the community, not an attempt to define syndromes of clinical or psychic phenomena’. It was argued that the *Act* regarded moral imbecility as a ‘social and legal’ rather than medical concern, and that the incentive of the *Act* was to confine the incurably criminal. Medical definitions of ‘clinical syndromes’ or ‘psychic phenomena’, declared

³⁶ Cyril Burt ‘The Definition and Diagnosis of Moral Imbecility (II)’ *British Journal of Medical Psychology* VI 1 (1926) 10-46 p. 15.

³⁷ Henry Maudsley *Responsibility in Mental Disease* (1872) pp. 31-65 quoted in Cyril Burt ‘The Definition and Diagnosis of Moral Imbecility (II)’ *British Journal of Medical Psychology* Volume VI Part 1 (1926) p. 17.

³⁸ Burt ‘The Definition and Diagnosis of Moral Imbecility (II)’ pp. 19-22.

Shrubsall, were relatively immaterial. If legal punishment, society's greatest institutional deterrent to crime, could not rectify his or her immoral behaviour, the moral imbecile was chiefly defined by the threat they posed to society.³⁹

For Henderson and Gillespie, such debates highlighted the lack of interest shown by society regarding what Shrubsall termed the 'psychic phenomena' of moral imbecility. As the *Act* categorised patients such as Miss M.B. alongside more overt forms of intellectual deficiency - those categorised as idiots and imbeciles - the act perpetuated the stilted and outmoded theory of degeneracy and its moralistic connotations.⁴⁰ Far from being a diagnostic category solely 'propagated', cultivated and controlled by the psychiatric profession, definitions of moral imbecility were torn between medical, legal and political constructs.⁴¹ Conceptual fissures, which can readily be detected in Henderson and Gillespie's *Text-book* account, arguably stemmed from such ruptures between medical and legal practices and discourses.

Miss M.B.'s medical identity

Since Henderson and Gillespie adhered to the dynamic principles of Meyer, we see how the *Text-book* endeavoured to undermine the legislation of the *Act*, as the case history of Miss M.B. was, in part, removed from the theoretical constraints of Victorian nomenclature. Placed within the wider diagnostic category of constitutional psychopathic inferiors, her case was used by Henderson and Gillespie to destabilise the moral imbecility diagnosis and reinvigorate it along psychobiological or dynamic lines. By stating, in alignment with Burt, that morality could no longer be defined as an innate sense, Henderson's description of Miss M.B.'s mental state in terms of perversions, abnormalities and emotional complexes revealed the faulty adaptation of an individual human organism to its entire environment, rather than placing her within a static, unworkable diagnostic

³⁹ F C Shrubsall 'The Definition and Diagnosis of Moral Imbecility (V)' *The British Journal of Medical Psychology* VI (1926) 70-83 p. 72.

⁴⁰ In 1939 Henderson wrote that: 'The term ... moral imbecility attained such a degree of popularity that it came to be defined and incorporated in the Mental Deficiency Act of 1913; in the subsequent Act of 1927 it was changed to "moral defective" and it is still in current usage. It is an obvious misnomer, it should be expunged from any subsequent classification' Henderson *Psychopathic States* pp. 10-11.

⁴¹ As Joan Busfield wrote: 'Once propagated, disease entities assume dimensions that the medical profession cannot always predict or control' Joan Busfield *Men, Women and Madness: Understanding Gender and Mental Disorder* (London: Macmillan Press Ltd, 1996) p. 119.

category.⁴² So, as the case history of Miss M.B. was situated in the ‘back yard’ where the chickens were drenched, the bedroom where stolen ornaments were hidden and the asylum wards where she struck the most helpless of patients, the case history of Miss M.B. bound her antisocial misconduct to distinct settings and social encounters. From within these small spaces of the private sphere, discrete acts of petty pilfering, aggression and antisocial misconduct were drawn out; to be analysed, diagnosed and published within the public arena.

It is precisely in this transition, from an individual life history comprising discrete encounters within distinct environments to the analysis of her behaviour through universalising medical discourses, that an unstable representation of Miss M.B.’s patient identity emerges. For, as psychiatric theory came into contact with the life history of Miss M.B., a conspicuous lack of ‘mental illness’ became glaringly apparent. In Henderson and Gillespie’s *Text-book*, Miss M.B. was described as antisocial and as lacking in altruism, yet Henderson makes clear that no demonstrable intellectual defects, nor overt emotional instabilities, could be detected. Miss M.B.’s abnormality lay with the ‘perversion’ of her emotions as the absence of distinct emotional complexes, yet such behaviour, conceded Henderson, did not constitute a ‘mental disorder in the usual sense’. Rather, the justification for her confinement lay less with matters of illness and more with ones of social and familial control. As she periodically transgressed the moral and legal codes of society, it was ‘on account of the difficulties of *management*’ [my emphasis] that she was certified as being of unsound mind.

As we first encounter Miss M.B. in the *Text-book*, we therefore begin to engage with a multiplicity of competing medical and social discourses that jostle, overlap and openly fracture as they are lodged within an individual case history. As Miss M.B. was certified and confined within the hospital, boundaries between the normal and the abnormal personality had no clear line of medical or legal demarcation. For those such as Miss M.B.,

⁴² In the introductory chapter of Henderson and Gillespie’s *Text-Book* (1927) p. 19, Henderson stated that: ‘The truth is, that no attempt at psychiatric classification is entirely satisfactory, and consequently that “diagnosis”, or the placing of the patient in the appropriate class, is on an unstable foundation. But, fortunately, it is not diagnosis that matters, but the understanding of the disorder, and of the patient who suffers from it – under what circumstances it arose, how it is related to the patient’s normal condition ... and what can be done to help towards a favourable outcome. In Adolf Meyer’s words, it is not the patients we are to sort out, but the facts: and while in the following pages the case records will be arranged in groups for the sake of more or less systematic description, the disorders exhibited will be considered as the individual reactions of a specifically endowed, and often constitutionally loaded, organism to the environment’.

straddling such boundaries, there is a sense of their liminality, of their inchoate social and medical identities in their transition from the social to the medical sphere. Bound to society through moral, legal and familial codes of conduct, Miss M.B.'s identity emerges from the conflation of ideas surrounding illness and antisocial behaviour. Yet, despite layers of knowledge, power and practice being inscribed within the published case history report, her case history presents us with an individual identity which is, from the outlook, predominantly unfathomable.

If one begins to strip away the overarching frameworks which infused Miss M.B.'s case history, at bedrock we encounter the representation of an individual defined by a lack of those essential emotional complexes which are commonly held to form the social being. Since she was reported to have 'jeered' at the morbid atmosphere of the sick room, her actions seem alien and her story evokes neither empathy nor understanding. Described by her family as a plausible and cunning liar, her words were bereft of authenticity, while her behaviour, shamefully concealed, was a family secret, a social disgrace. We, as a readership, engage with a symptomatic description of an abnormal personality set against social and clinical backdrops, but such an analysis does little to unveil the subjective meaning of this patient's actions and words. Once her case history was situated within the asylum, her identity within this published report remained an enigma. Henderson's *Text-book* description of her unreliable and petulant behaviour did little to evince the psychobiological approach which relied so heavily upon the analysis of the patient's subjective story. This chapter therefore turns inwards, to the archival materials upon which Henderson himself relied in creating his picture of Miss M.B., but which, I would insist, serve as situationally shifting sands for any kind of 'medical' portrait, however nuanced.

Miss Margaret Beaton, admission and adaptation to a new environment

One night in early spring 1921, Miss Margaret Beaton, a young woman from a small town on the outskirts of Glasgow, stepped from a motorcar and was escorted by two nurses and her elder brother to the entrance of Glasgow's Royal Asylum. Once inside the building, she showed little resistance to the asylum staff as she listened in silence to the admission procedures. Refusing to acknowledge her brother as he made his departure from the entrance hall, she nonetheless let herself be led away by the nursing staff. Escorted through the asylum building, she was seen to hesitate, brief moments of resistance punctuated her

progression along the corridors and tears began to flow before she was washed, fed and put to bed in the female admission ward alongside other newly admitted patients.⁴³

Earlier that afternoon, Miss Beaton's younger brother had called for their family doctor as it was considered a matter of great urgency that his sister be examined within their family home. Upon the doctor's arrival, Miss Beaton was found to be in a highly resistive temper. Unlike the silent and compliant manner displayed at Gartnavel, her conduct earlier that day had been actively defiant. Rebuking every effort made by the doctor to engage her in conversation, she tore through the house 'slamming doors behind her, making as much noise as possible and locked herself away from observation'.⁴⁴ Miss Beaton's protestations made a thorough medical examination impossible, but, despite such difficulties, it was upon information provided by Miss Beaton's brother that a Certificate of Emergency was drawn up, enabling her immediate removal to Gartnavel. In the doctors report it was written:

Her brother informs me that for some years she has threatened (and has done) violence to various members of the family, and has of late turned her attentions towards her mother, who for over three weeks has been compelled to seek safety behind locked doors. [She] has a fixed delusion that all the other members of the family are conspiring against her and excuses her acts of violence and destruction as "punishment".⁴⁵

Having placed his signature on the certificate, the doctor legally testified that upon his 'soul and conscience' he had that very day 'seen and examined Miss Beaton'. Declaring his patient of 'unsound mind', she was, by his medical opinion, 'a proper person to be placed within an Asylum'.⁴⁶ Miss Beaton's brother, who acted as the surety and petitioner to her case, then placed his signature beneath that of the family doctor, securing his sister's immediate removal to Gartnavel. Under such fraught circumstances, two nurses were

⁴³ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 (1921) NHSGGCA.

⁴⁴ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 Medical Certificate No I (1921) NHSGGCA.

⁴⁵ Ibid.

⁴⁶ Admission Documents: Male and Female GB812 HB13/7/128, (1921) NHSGGCA. As the legal process of certification clearly stated that two medical certificates were needed before a patient could be certificated, only those patients who were brought in under the 'Urgency Order' could be admitted as non-voluntary patients under such circumstances. Such patients were regarded as posing an immediate risk to either themselves or to the safety of others. Henderson and Gillespie's *Text-Book* (1927) recommended that such individuals should be dealt with 'forthwith' p. 488. Evidence given by a family member which petitioned for an individual's certification accompanied by a single medical certificate was all that was necessary to retain patients such as Miss Beaton within an asylum for 7 days before a further medical certificate was required. Evidence relayed by the petitioner was therefore of vital importance to the process of certification and was duly documented within the patient's case note records.

called upon to help prize Miss Beaton from her locked room and to escort her to Gartnavel. Upon entering Miss Beaton's bedroom, the nurses found Miss Beaton's belongings to be 'in a state of indescribable confusion'. After locking herself away, Miss Beaton was sitting in the dark among such chaos. Unwilling to leave her home, she threatened to destroy herself. Declaring she would take poison and throw herself out of the window if they tried to remove her, the nurses evidently faced a highly charged and potentially dangerous situation. Exactly how Miss Beaton was removed from her home is omitted from the records, but it is evident that, despite protestation, she was seated in an awaiting motorcar and, alongside her brother and two nurses, conveyed to Gartnavel.⁴⁷

In Miss Beaton's case note records, it is from such an array of perspectives that we first learn of her hurried examination, silent admission and cold farewell. Networks of observation penetrated the domestic sphere as relatives, doctors and nurses facilitated her removal to Gartnavel. Once in the hospital, these diverse perspectives were drawn together; medical certificates, nursing reports and family petitions were collated and copied into Miss Beaton's case note records so that her story up to the point of admission was constructed. In accordance with the psychobiological approach, the medical record was furnished so that her symptoms were integrally bound to the social backdrop in which they had naturally occurred. Piece by piece, Gartnavel's medical officers then began to construct a linear personal history of his patient. Through such fragmentary reports, the violent outbursts, persecutory delusions and emotional disturbances recorded in Miss Beaton's certification documents could begin to attain meaning beyond that derived from the symptomatological approach of the family doctor.

As previously stated, Henderson's method of case note taking was heavily influenced by the work of George H. Kirby, himself an ardent follower of Adolf Meyer. The statement made by Kirby, that it was usually of little importance that a patient 'does or says a certain thing' but rather 'that he does or says *it in a definite setting*', exemplifies the approach to case note taking applied by Henderson. Because the setting gave 'the act or utterance the value of adequacy or inadequacy', each disruptive act or emotional outburst was viewed as a form of adaptation which became meaningful, only once analysed against the environmental settings where they occurred.⁴⁸

⁴⁷ Nurse report quoted in Medical Certificate No II 5th May 1921 GB812 HB13/5/176 NHSGGCA.

⁴⁸ Within the index of Henderson and Gillespie's *Text-Book of Psychiatry*, Kirby's *Guides for History Taking* was referred to as one of the 'principal works referenced to in the text'. See p. 57 in Kirby's text in

Observed in her transition from the clutter of a dimly lit bedroom to the entrance hall of Gartnavel, her records focus upon such a sharp transition, tracing her adaptation to the ‘strange experimental stage’ upon which she was required to act. As she was escorted to the admission ward and initiated into the hospital routine, she was removed from the social backdrop against which her symptoms were previously viewed with such ‘bold and striking relief’. Viewed instead against a controlled, clinical environment, the ‘medical gaze’ pervading the building, its regulations, patient population and staff all became part of the new ‘experimental stage’ upon which Miss Beaton’s actions and utterances were to be observed and recorded.⁴⁹ In the *Text-book* Henderson and Gillespie (as previously noted) claimed that during this transitory period, ‘[a] good deal can be learned from the way the patient adapts to a new environment’. Upon the admission of patients to the asylum, practitioners and nursing staff were trained to ‘note at once’ in the appearance of the patient ‘whether there is depression, or elation and talkativeness, apathy and listlessness, co-operation or resistance’.⁵⁰ Miss Beaton’s refusal to part upon equitable terms with her brother, as well as brief moments of resistance along the asylum corridors, were notable features of her medical record. It was from this vast system of surveillance and record keeping that Miss Beaton’s *patient* identity began to be constructed at Gartnavel.

Compiling a family history

After Miss Beaton’s brother had escorted his sister from the motorcar and watched her departure along the hospital corridors, he was invited by a medical officer to provide further details about his sister’s family history. Unlike the family doctor who reiterated this brother’s statements, case note records reveal the informant was questioned most carefully with due regard to the subjective nature of his story. The brother began the interview by stating his sister was the eighth child in a family of nine, with there being four sisters and five brothers all alive and well. Turning to the subject of hereditary insanity, one of their brothers, he revealed, was ‘a medical [man who] was eccentric enough to wear a beard when a student at college...’. At a time when ‘...it was custom to be clean shaven and even

regards to the mental examination and the importance of the setting in which utterances and actions occurred.

⁴⁹ Henderson and Gillespie *A Text-Book of Psychiatry* (1927) p. 81.

⁵⁰ *Ibid* p. 74.

a moustache was uncommon', abnormality, it was implied, afflicted more than one member of the family.⁵¹ For the psychiatrist who interviewed this brother, eccentricity was indeed seen to characterise certain members of Miss Beaton's family, for, as the informant sat in front of the psychiatrist, he himself was regarded as a most 'curiously exact gentleman'. Referred to by the medical officer as a man who 'must get all his facts out in his own slow, particular, rather ultra-polite way', the value of this interview seems to have lain not only with the content of the brother's narrative, but also with the psychiatrist's analysis of this entire linguistic performance.⁵² Alerted to the precise composition of the brother's sentences, to the rhythmic tones by which each word was slowly, deliberately articulated, the somewhat peculiar, individualistic natures of the two brothers seemingly indicated a constitutional predisposition to eccentricity and abnormality.

Being unaware, in all likelihood, that his own mental state was being so closely evaluated, the brother continued to inform the interviewing psychiatrist that his sister had always had 'a violent antipathy towards somebody'. Six members of her family, he stated, had 'fallen into disfavour', while her adolescent years, education and employment history were blighted by her inability to get on with others. He considered that it was on account of her antagonistic character that she did not progress well at school. When she was sent out to work, she repeatedly met with rejection, to the point that she refused to seek further employment. During the past year it was noted she had, while:

... in one of her angry moods, turned on the gases without lighting them, so that it has been necessary to use candles. She has neglected her appearance of late, and being on a small allowance has gone out and sold her good clothes and dressed in shabby ones in order to get money. She does not work about the house, or little. Said one occasion lately that she wouldn't work at anything at which she would fail, and she would fail at anything she tried; and so does nothing.⁵³

In this statement, descriptions of her behaviour began to correlate with contemporary accounts of moral imbecility known to the British psychiatric profession. As her records reveal she had always been considered 'strange' by the family, the longevity and seeming permanency of her antisocial behaviour corresponded to the widely held notion of moral imbecility as an innate, incurable form of mental defect. Characterised by asylum practitioners such as Tredgold as persons exhibiting a persistent, fixed and innate absence

⁵¹ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA.

⁵² Ibid. Examination undertaken by Henderson, 5th May 1921.

⁵³ Ibid.

of the 'regulating capacity' to conform to the moral standards of society, her emotional outbursts, destructive actions and parasitic lifestyle were symptomatic of such a diagnosis.⁵⁴ But, because contemporary psychiatrists were also questioning the widely held notion that moral deficiency was hereditarily determined, the significance of the above quotation becomes more complex. For, as the recording psychiatrist picked up upon the pessimistic attitude displayed by Miss Beaton towards her working capabilities, and also the relative poverty suffusing her domestic environment, the diagnostic picture expanded into the economic sphere.

In the latter years of the First World War a sociological perspective was encroaching upon British psychiatric literature, with German psychiatrists such as Karl Birnbaum suggesting that the term 'sociopath' be used to designate such personalities. Not all those regarded as possessing a psychopathic personality, argued Birnbaum, were constitutionally predisposed to commit immoral or criminal acts. Rather, their antisocial behaviour was understood as a reaction to a rigid and unaccommodating system of legal, moral and economic laws that regulated society and which offered such personalities little chance to acquire meaningful social roles.⁵⁵ Sociologically informed psychiatrists therefore began to explore how environmental factors such as poverty might shape the behavioural patterns of such individuals. In an article, anonymously published in the prestigious medical journal *The Lancet* in 1917, it was argued that it was the 'defective born in surroundings of poverty' whose downfall became most natural and easy. The moral imbecile, it was reported, often acquired the reputation at school of being perverse, lazy or stupid; and, after they were sent out to earn their living, the discipline of the workplace often aggravated the antisocial tendencies of the defective personality. Faced repeatedly with rejection from employers and colleagues, their inability to secure, or succeed in, their employment meant that they became 'used to failure'. Rejected from society and unable to earn a living, their 'appetites and desires' were nonetheless noted to be as strong as the average individual, but, as they had 'not the capacity for inhibition or realising the wrongness or consequences of evil-doing, their downfall became easy'.⁵⁶

⁵⁴ A. F. Tredgold *Mental Deficiency (Amentia)* (New York: William Wood and Company, 1920) pp. 348-361.

⁵⁵ Theodore Millon, Eric Simonsen and Morton Berket-Smith 'Historical Conceptions of Psychopathy in the United States and Europe' in *Psychopathy, Antisocial, Violent and Criminal Behavior* eds. Theodore Millon, Eric Simonsen et al (New York: Guilford Publications, 1998) p. 12.

⁵⁶ Anon 'The Moral Imbecile' p. 459-60.

Miss Beaton's failure at school and her rejection from the work place would duly take on differing layers of meaning if analysed from such a sociological perspective. As facts garnered from this interview built up a picture of Miss Beaton as an individual at odds with her social environment, the pessimistic attitude she showed towards her own capabilities and the underhand means by which she acquired money while 'being on a small allowance', could be explored as a means of *adaptation* to societal pressures and economic circumstances. Miss Beaton's personal history demonstrated that she continually failed to conform to social expectations, and that she failed to learn from experience or comprehend the moral implications of her actions. Discrete acts of aggression, theft or irritability may thus have attained meaning once they were understood, not only as the product of constitutional predispositions, but, as the faulty adaptation of an entire human organism to its environment.⁵⁷

Coming to the end of the interview, her brother informed the recording psychiatrist that the question of his sister being certified had arisen by 1919 and was recognised by their medical brother as a likely possibility, but that this decision had been held over until the last three weeks before her admission when her behaviour had escalated to physical violence:

The present state of affairs was come to by her getting very violent and threatening to her mother who had to lock herself into a bedroom, and on morning of 4th [the day of her admission] the mother was threatened with a broom and later catching her unawares patient struck her.⁵⁸

It is therefore clear that certification was necessitated primarily by the need to control her violent behaviour rather than the recognition of mental illness *per se*. Social disharmony and familial discontent pervade this brother's description of his sister, but only when her behaviour directly threatened those around her was it considered just to label her insane and remove her from the family home. The power to define and confine such patients therefore primarily lay with the family. Once Miss Beaton instilled fear at home, her family's inability and unwillingness to continue accommodating her was the point at which

⁵⁷ Within Henderson and Gillespie's *Text-Book* (1932) p. 73 it was written that in order to gauge a patient's intellectual abilities one should acquire a detailed account of the patient's 'ability to be guided by past experience. These points can be elicited by having a detailed account not only of the patient's school days, but also of his business and family life'.

⁵⁸ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHHGGCA.

certification was deemed necessary, an external dynamic that must be kept in mind when assessing her whole case. As she was tied so closely to her family through relations of economic dependency, her discharge from Gartnavel would very much depend upon her family's willingness to reabsorb her into the domestic circle. The case record therefore alerts us to this complex matrix of power relations, flowing between patient, practitioner and her family, that we, as historical researchers, must explore when examining the construction of Miss Beaton's medical, social and personal identity.

Before this interview came to an end, one final remark made by Miss Beaton's brother was that despite his sister's antisocial characteristics 'she can be very pleasant when she likes'. Such a remark is suggestive of a vast changeability of character, of the periodicity by which her symptoms ebbed and flowed. But it is also interesting to note that such a statement is reflective of the fears, long voiced by those within the psychiatric profession, of the ability of the moral imbecile to manipulate and exploit those around them. Regarded by many practitioners as plausible, loquacious and vibrantly imaginative individuals, such positive attributes were often seen as a veil of normality, as a false façade behind which they could conceal their underlying moral defects.⁵⁹ It will be interesting, in the analysis to come, to see how such dichotomous and changeable characteristics were reacted to within the institution.

After this interview was completed and her brother had left Gartnavel, Miss Beaton remained in bed in the female admission ward until the following day when a second medical officer, Dr. Jane Suttie, visited her. After Miss Beaton had spent her first night in Gartnavel, Dr Suttie found her to be very emotional, but open to discuss her situation. In the examination Miss Beaton stated that she suffered greatly within her family home, that she received no affection or consideration from her mother and siblings and that the entire family were against her. Her mother was particularly criticised for grudging her food and for being 'spiteful'. Regarding the incident when she turned on the gas lamps without lighting them, she justified her actions by stating it was merely a means by which to compel her mother to spend money. Once again it is this relation between the strength of the acquisitive instinct, the weakness of inhibitory capacities and a lack of appreciation as to the moral consequences of her actions that were noted to characterise Miss Beaton's

⁵⁹ On the subject of the moral imbecile's magnetic personality see such articles and text books as that of C. P. Obendorf 'Constitutional Inferiority and its Psychosis' *The Journal of the American Medical Association* January 27th (1912) LVIII p. 249 and Clouston *Clinical Lectures* p. 373.

condition. In assessing Miss Beaton's statements, Dr Suttie's report concluded that she 'had no sane insight into the significance of her conduct' and therefore she placed her signature on the Certificate of Emergency. With two independent examinations having been made, each certifying the mental instability of Miss Beaton, these documents were collated alongside the brother's petition and placed in front of the county Sherriff. His final signature upon the Certificate was obtained that day, ensuring Miss Beaton remained within Gartnavel as a certified patient.

A certified patient and the mental examination

That morning, as Miss Beaton lay crying in bed, Henderson and an accompanying clinical clerk entered the ward and sat beside her. With pen and paper in hand, a preliminary discussion between Henderson and Miss Beaton ensued, followed by the formal mental examination. Having been informed by a ward nurse that Miss Beaton had not slept since her arrival, Henderson found his patient to be in a highly emotional state. Frequently sobbing throughout the interview, her general sullen appearance was noted by the clinical clerk, while Henderson, guided by the Meyerian approach to case history taking, began an analysis of his patient wherein 'different mental fields' (grouped by Henderson as those of 'behaviour', 'personality', 'intellect', 'affect' and 'insight') were systematically explored.⁶⁰

As Henderson opened the conversation with a succession of simple questions, asking Miss Beaton to confirm her name and her general complaints, the purpose of these preliminary inquiries was to elicit a 'verbatim sample' of her spontaneous speech.⁶¹ In obtaining a perfectly lucid response from Miss Beaton, no evidence of organic disturbance was noted in the interview transcript and therefore Henderson began to enquire into the degree of insight that Miss Beaton had into her condition.⁶² Endeavouring to ascertain whether she considered herself mentally ill, whether she would cooperate or resist the examination process, he directly asked:

⁶⁰ Following Kirby's *Guide* my own analysis was carried out under the headings of: 1. Attitude and General Behavior of the Patient. 2. Stream of Mental Activity. 3. Emotional Reaction, Affect and Mood. 5. Mental Trend, Content of Thought. 6. Reasoning. See chapter 4.

⁶¹ As periods of mutism, distractibility or the erratic and disconnected flight of ideas could often characterise a patient's narrative, such linguistic disturbances were taken to signify underlying functional disorders, see Henderson and Gillespie *Text-Book of Psychiatry* (1927) pp. 74-75.

⁶² Within Henderson and Gillespie's *Text-Book of Psychiatry* (1927) pp. 80-81 it was written that in the mental examination the interviewing psychiatrist should question 'the amount of realisation the patient has of his own condition; does he realise that he is ill, that he is mentally ill, that he is in need of treatment in a mental hospital?'

“And why are you here?”

“I was foolish, selfish and stubborn [replied Miss Beaton] and rather a bad temper and this is what they’ve done”.

“Who? your mother and brother?”

“Yes. Do you think I’m like these people round about” (the patients).

“Depressed?”

Her home, she replied, was depressing, characterised by “poverty and unhappiness”. Her mother was described as a woman who would “never give into anything”, “was suspicious of everyone” and whose old fashioned ways clashed with her own. Henderson suggested that her mother’s suspicion may have been justified, as he reminded Miss Beaton that she had herself threatened her mother. “I didn’t mean it”, she responded.

As Henderson drew the conversation towards the domestic sphere, Miss Beaton’s actions and emotions began to take meaning as tangible environments became the backdrop against which her story was set.⁶³ As the ‘colouring of the psychosis’, argued Henderson, ‘was largely dependent upon the original make-up, constitution or personality of the individual’, Henderson needed to tease out of the conversation a longitudinal history, one which demonstrated whether such emotional outbursts and depressive states periodically reoccurred throughout her life history (and were characteristic of her personality), or whether such incidents were more dependent upon present environmental factors and might therefore be more amenable to treatment.

Asking whether Miss Beaton could explain her general irritability she replied;

“I haven’t had anything that other girls have had”.

“Life’s hard?” suggested Henderson

“Yes”

“Sick of the thing?”

“Not all together.”

In enquiring about her friends, Miss Beaton replied that she was always “one too many”, that no one took her side and that everything was always blamed on her. As Henderson reflected upon a history of fraught familial relationships and social isolation, the

⁶³ As Adolf Meyer wrote in his introduction to the study of psychiatry at undergraduate level; ‘it seems to be quite insufficient that anybody should be described without further question as depressed “without adequate cause” ... I must look for the completion of the “story” beyond the immediate surface ... into a broader setting, including also the organism and what the event or development is part of. Meyer in *The Collected Papers of Adolf Meyer, Volume III Medical Teaching* p. 117.

depression, anguish and anger she exhibited within the mental examination could begin to be analysed from a longitudinal perspective. She blamed her ‘stubborn, selfish’ and ‘irritable’ characteristics upon her mother’s refusal to “give in” to her requests, to the relative poverty of the household and to a lack of personal possessions, which, she argued, marked her from her peers. Miss Beaton’s failure fully to appreciate the significance of her aggressive conduct, alongside her lifelong inability to conform to the standards of society, most likely signified to Henderson that a constitutional defect was at the heart of her antisocial behaviour.⁶⁴

As she projected the source of her troubles on to others, Henderson tried to reassure her that her family wanted to make her better, but to such a remark she replied:

“I don’t think so. Do many a thing for punishment”

“We want to help you” [stated Henderson]

“I don’t think it’s the way to make me – not people, the type of people.”

[To Miss Beaton’s somewhat hesitant remark, Henderson added that] “it worked out although not apparently likely on surface.”

“That isn’t so” [she refuted.]

A succession of distinct statements made by Miss Beaton followed on from this line of discussion:

“They’re very clever; I’m not so clever: all doctors or ministers etc”

“I’m the 8th”

“I can never go back to [name home town]”

“Dr ... will spread it all over: at the tennis courts”

“I know your taking notes”

“Mind clear?” [asked Henderson]

This has ruined me. They’ll triumph over me; they “don’t care a bit”

This idea was disagreed by Dr Henderson; but she persisted it was so.

As Miss Beaton insisted that her removal to Gartnavel was a form of punishment, that her intellectually superior family had triumphantly sullied her reputation and cast her from her home, the intensity of her emotions, depth of her despair and strength of her antagonism

⁶⁴ In support of this claim, in 1932 Henderson wrote that ‘A person well-endowed intellectually, who has met his difficulties in his social, business and sexual relationships in a healthy, straightforward way, ... who has been “exteriorized” in his every day relationships, has always much more of a chance of making a good readjustment than his introverted, “shut-in” neighbor’. Henderson and Gillespie *Text-Book of Psychiatry* (1932) p. 73.

flowed out in one long tirade. As Miss Beaton vented her feelings, the flow of the dialogue began to jolt and splinter and momentarily she turned her attention away from Henderson and confronted the clinical clerk: “I know you’re taking notes”, thus breaking away from the enclosure of a two-way dialogue. All at once we are reminded that this interview was carried out, not within an enclosed and private space, but on an open ward, among medical staff of whose gaze she was fully aware. Behind the overt content of the mental examination report, we are subtly alerted to her surroundings, to the recording mechanisms that actively shaped her dialogue and to an indistinct, yet pervasive sense of the clinical atmosphere still infusing the transcript.

As she diverted the conversation to reflect upon the patients who surrounded her - “Do you think I’m like these people round about” - we are alerted to presence of those other bodies. As rows of beds furnished the ward, their occupants evidently encroached upon her mind. As she lay among them, her broken yet defiant statement that she was not to be helped by the hospital, - she did not “... think it’s the way to make me – not people, the type of people” - her stammering response hints of resistance to the hospital’s intervention, to the imposition of a patient identity. By this point she began to dominate the discussion by disregarding Henderson’s line of questioning, but Henderson strove to harness the direction of the interview, persisting in his line of questioning as to the content of her thought.⁶⁵

Imaginations? Or Voices?
“No never” [she replied]
Thinking and concentrating?
Said had no difficulty.

With neither delusion nor hallucination appearing to steer the course of Miss Beaton’s narrative, her life history, punctuated by emotional instability and antisocial conduct, was weighing heavily towards the diagnosis of moral deficiency. Meyer, in the 1910s, recognised that the increased sensibility and impressionability of such individuals provoked feelings of paranoia, so Miss Beaton’s intense distrust of her family completed

⁶⁵ Within Henderson and Gillespie’s *Text-Book of Psychiatry* (1927) it was stated that while taking the mental examination ‘It often happens that when a patient is describing his “feelings” he will express ideas pointing to a disordered content of thought, and at this point he should be encouraged to detail the development of his ideas’. Question such as ‘Do you hear voices or noises’ were advised to be asked in order to ascertain whether the patient’s expression of their ‘feelings’ occurred ‘in a setting of complete intellectual clearness’ pp. 76-77.

the diagnostic picture.⁶⁶ Finally, in turning the conversation to a more congenial topic, Henderson asked Miss Beaton about her preference for reading. She volunteered that she liked reading, that ‘just now’ she was reading “East Lynne”, but Miss Beaton used this opportunity once again to contest her certification:

“I’ve read of people being put in asylums”,
Dr “neither saw me nor examined me”
“I have not spoken to his son”...
“He came last night and I did not see him”.
That is not a just certificate at all.

As Miss Beaton leaned upon such literary portrayals of asylums to argue her certification was void, her resistance was absolute. The degree to which a patient was willing to cooperate with the initial stages of their admission was, for Henderson, a decisive indicator as to the prognosis of the case. Since Henderson wrote in 1914 that ‘success or failure in the treatment of a case depends to a tremendous extent upon the degree of cooperation’ shown by the patient and their family towards psychiatric care, Miss Beaton was making a poor first impression.⁶⁷ Henderson encouraged Miss Beaton to speak freely about her problem and, to tell her story. Attempting to form a bond of trust by reassuring Miss Beaton of the institution’s willingness to help, she nonetheless rejected such offers, refuting the legality of her certification. Henderson wrote that it was with such patients that the ‘trials of management come to the front’. It was ‘entirely wrong’, argued Henderson, to allow a patient to ‘dominate the situation’, for them to ‘play the part both of the physician and the patient’.⁶⁸ A distinct role, it seems was allocated to the patient, one which, if not voluntarily adopted, was coercively reinforced.

Before the interview came to an end, the final remark made upon Miss Beaton’s records showed the conversation returned once again to the incident when she turned on the gas taps in her home without lighting them. Her records summarised the situation by saying ‘she showed an entire lack of appreciation of her conduct and of how it would weigh in the eyes of others’ thinking ‘that it was perfectly just to turn on the taps because her mother was “so mean” and that would simply make her spend money’. This entire lack of appreciation, for Henderson, was one of the most significant factors in Miss Beaton’s case.

⁶⁶ Adolf Meyer ‘Notes on the Subject of Constitutional Inferiority’ Box XII/1 Folder 59, Baltimore Working Notes, AMC p. 6.

⁶⁷ Henderson ‘Remarks on Cases Received in the Henry Phipps Psychiatric Clinic’ p. 69.

⁶⁸ Ibid p. 71.

Such an outlook, wrote Henderson in 1914, was in itself ‘sufficient to make one take an ominous view of such cases’.⁶⁹

Finally, as her mental examination came to an end, we arrive at the formal diagnosis. Upon the opening page to her case note records, the following classification was made:

Form	Constitutional Inferiority ; Moral Defect
Cause	Congenital
H.P.	-
Duration of Attack	Congenital

With the form of mental disorder being defined as one of ‘Constitutional Inferiority; Moral Defect’, it is interesting to note that her diagnosis conflated terms, stemming from British, North American and Germanic origins. Since the term moral imbecility was being criticised at this period as a stigmatising and medically limited diagnostic term, the case history of Miss M.B. was, in part, removed from such theoretical constraints. In effectively rejecting the term ‘moral imbecility’, Henderson cast off the connotation of intellectual deficiency that was commonly held by ‘the plain man’, the ‘doctor, magistrate or teacher’ - inferred by the term ‘imbecility’.⁷⁰ Placed within the wider diagnostic category that defined such individuals as constitutional inferiors, Henderson was utilising psychobiological theories to destabilise and reinvigorate the moral imbecility diagnosis, and yet, by retaining the notion of a *moral* deficiency, he held on to a term itself laden with ethical overtones that conformed to the nomenclature of British psychiatry.⁷¹ Miss Beaton’s case history was hence posited precariously, balanced between the moral deficiency and constitutional inferiority diagnostic categories, and here we encounter the sharp end, as it were, of an unstable and evolving diagnostic category. As this chapter traces the evolution of her case within the asylum, it is these instabilities, fractures and competing theoretical threads that will be explored.

⁶⁹ Henderson ‘Remarks on Cases Received in the Henry Phipps Psychiatric Clinic’ p. 69.

⁷⁰ Cyril Burt ‘Delinquency and Mental Defect (II)’ *British Journal of Medical Psychology* 3 (1923) 168-178 p. 171 originally published in a contribution to a symposium presented at the Joint Meeting of the Educational Section and the Medical Section of the British Psychological Society, April 25, 1923.

⁷¹ Constitutional inferiority is defined by Adolf Meyer in 1915 in his unpublished and untitled working notes, XII/1, Folder 59, Baltimore: Working Notes, AMC.

A little more attempt to “carry on”

In the days that followed, Miss Beaton’s records reveal that, after ‘weeping for nearly 24 hours’, she made a ‘little more attempt to “carry on”’. Her mood, it was noted, had begun to temper, she slept and ate well, even laughed on occasion, but she sent the ‘most piteous letters of appeal to her mother and brother saying what agony she was enduring’. ‘Her mood’ it was reported was ‘certainly not at one with her declarations’; indeed, an extreme changeability was noted to characterise her behaviour. ‘It is very interesting’, it was noted within her records:

... to hear her appeals to get away in the variation of mood wh. she shows; at one time she declares she is being tormented in a piteous tone, next moment with her eyes sparkling she attempts to cajole the Dr and get him to promise, this failing she declares with an expression black and angry that she is only being kept for the fee.

Such interest shown in the variation of Miss Beaton’s mood, and the incongruity between her thoughts and emotions, arguably reflected Henderson’s interest in the *dynamic* approach to the analysis of such personalities.⁷² For, just as psychiatry in Britain in the 1920s was slowly moving away from the determinist principles of degeneracy theory, a fusion of psychoanalytic, anthropological, psychological, anatomical and physiological disciplines meant that the antisocial tendencies, emotional outbursts and paradoxical characteristics displayed by the morally deficient were being quarried for new meanings across such emergent conceptual frameworks. Unlike the contemporary views of eugenicists such as Tredgold, who continued to regard the emotional outbursts and incongruous thoughts of the ‘moral imbecile’ as originating from an innate lack of *moral sense*, dynamic psychologists such as Burt rejected this essentialist conception of morality.⁷³ Rather the paradoxical behaviour of such problematic personalities was reconceptualised as originating from:

... a lack of balance between instinct and emotion, on the one hand, and ... the intellectual organisation of these tendencies, upon the other.⁷⁴

⁷² On the subject of dynamic psychology and studies into the individual see Meyer ‘The Value of Psychology in Psychiatry’.

⁷³ Tredgold *Mental Deficiency (Amentia)* p. 122 wrote that ‘[t]he moral, ethical, or social sense is that by which we appreciate right from wrong’.

⁷⁴ Burt ‘Delinquency and Mental Defect (II)’ p. 172.

Incongruity between emotion, instinct and intellect comprised the ‘constitutional deficiency’ from which the vast fluctuations in mood and thought were envisaged to stem. Their erratic behaviour, it was postulated, was the result of the ‘moral imbecile’s’ inability to control their emotions and primitive instincts, or to ‘sublimate’ their egotistical tendencies. As to the precise manifestation of such deficiency, this was seen to depend largely upon environmental factors. With personality understood by Henderson as the result of a steady accumulation of ‘memories, sentiments and habits’, so were the dominant traits of the moral imbecile’s personality envisaged. Regular patterns of ‘thinking, feeling and acting’ acquired throughout life by a ‘slow and painful process’ were taken as the manifestation of one’s character, and therefore the extreme changeability of Miss Beaton’s behaviour demanded not only that the innate constitution – that is, the strength and weakness of her emotions, intelligence and instincts – be scrutinised, but also that her memories, thoughts and feelings be ploughed for meaning.

By noting how quickly the sparkle in her eye changed to a black and angry expression, Henderson began such investigations by portraying her adaptation to distinct environmental stimuli and social pressures. Likewise by retaining her correspondence, Henderson preserved a narrative by which he could demonstrate the distinct ruptures and contradictions demarcating her outer expressions from her inner thoughts and emotions. Through the analysis of a collection of letters written by Miss Beaton, which were censored and retained within her medical files, this chapter begins to move away from the assessment of Miss Beaton’s clinical identity, to consider how she herself countered the imposition of such an identity. By contextualising these letters against both correspondence sent by her family and her case note records, I chart her portrayal of her sense of self to an array of audiences from within the confines of the asylum.

Admission and incarceration, from a patient’s perspective

The inmate... finds certain roles are lost to him by virtue of the barrier that separates him from the outside world. The process of entrance typically brings ... loss and mortification. [Due to] admission procedures, such as taking a life history ... assigning numbers ... undressing, bathing ... and assigning to quarters ...⁷⁵

As Miss Beaton was certified and initiated into the asylum community, she entered an environment where both her mind and body were to undergo a process of re-identification.

⁷⁵ Goffman *Asylums* pp. 25-26.

As she was washed, fed and placed on a ward, she became part of a patient community, united by the physical barriers of the hospital's interior and by their shared status as mental patients. Several mornings after her arrival, Miss Beaton wrote a letter to her mother in which she described the admission process. After having failed to smuggle this letter out of Gartnavel, her plea for release could not elicit a contemporary response from outside of the hospital, and yet, it enables us, ninety years on, to engage with a patient's response to certification which is untainted by retrospection, demonstrating instead an immediate, if somewhat mediated, reaction to the admission procedure.

My Dear Mother ...

9/5/21

I implore and beseech you take me out of this – you couldn't know what you did when you put me among jibbering, moaning, screaming idiots. Come for me today and take me home, do not let me be another night enduring this living death.

...Oh have pity on me and release me, one word from you would do it... I know I was doing wrong but I was embittered. I am sorry, so sorry... The doctor says that my mind is perfectly clear – that being so, can you imagine the agony I am going through. I cannot describe this frightful place – the indignities that are put upon me and the terrible sights and sounds I hear all day long. Each day seems like a thousand years of Hades... think of my feelings when two nurses stripped me and bathed me with a filthy sponge (you should have seen who it had been used for first) and cut my toe nails. I am forced to take food I do not want - those who do not take all they are given are forcibly fed, so I have to almost choke myself in self defence. It is all intolerable-besides lying in a ward (and I have been all this time) surrounded by filthy raving lunatics. Mother please have mercy - remember "Blessed are the merciful for they shall obtain mercy" - and take me home ... A kind nurse is sending this note for me. Oh listen to my pleadings. I am praying to God all the time that you will.

Your miserable and repentant child

Margaret.⁷⁶

This letter, written to her mother on the fourth day after her arrival, was one of many letters where she forcefully disassociated herself from the hospital regime and the patient community. As she described the bodies of those surrounding her as 'filthy' and their speech as 'raving, jibbering and moaning', Miss Beaton used these images of the dirty, animalistic lunatic to describe a patient community whose identities, she argued, were entirely alien to her own. Being stripped naked, washed and forcibly fed, Miss Beaton's letter evoked a sense of disempowerment and violation. Dirty sponges brought her into

⁷⁶New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA pp. 157-8.

contact with the ‘filth’ of those who surrounded her, while the forced ingestion of food is suggested the invasive nature of the hospital regime. Indeed, as one mulls over this letter, the more the hospital atmosphere is felt to coat the skin, to enter the body, to strip away the material semblance of a former identity. As she lay in the ward, surrounded by the other patients, one senses Miss Beaton’s frustration and desperation to resist the imposition of a patient identity.

At the time Miss Beaton portrayed the patients who surrounded her with such disdain, she had actually spent a mere three days within the asylum. Lying in bed all this while, her interaction with the other patients would have been brief and yet she used such provocative prose to portray a homogenous body of patients whose identities, she argued, were so decidedly alien to her own. To explore further the contents of this letter, to question its meaning as a *reaction to*, rather than a *reflection of*, the asylum environment, this narrative must be embedded within the wider social and historical context in which it was penned. By borrowing from the work of Kerry Davis, I hope to tease out threads of meaning held within this letter and to detect how Miss Beaton fought to define her own identity within the confines of the institution. As Davis’ work on the narratives of patients within late-twentieth century mental hospitals contends:

Patient narratives are informed by both lay and psychiatric discourses of madness. Patients negotiate and utilise the various different languages of madness and mental illness available in order to establish meaning – to re-construct and to narrate their experiences.⁷⁷

As her letter was written to her mother with the purpose of securing her release, I would argue, echoing Davis’ statement, that such a narrative was, to some degree, a fictional construct and literary device weaving subjective experiences within more powerful and pervasive discourses. Miss Beaton fought against the imposition of a patient identity, and the following section investigates the stylistic devices, the discourses, the stories, the memories and experiences interwoven within her own narrative. The contents of *East Lynne*, the novel that Miss Beaton admitted to be reading upon her admission to the asylum, may throw some light upon the fervent distinction made by Miss Beaton between her identity and that of the patients surrounding her.

⁷⁷ Davies ‘A Small Corner that’s for Myself’ p. 308.

East Lynne, a Victorian sensationalist novel, was popular among a middle-class female readership, becoming a staple melodrama of the Victorian stage and early-twentieth-century cinema.⁷⁸ Its plot entwined themes of love, passion and hereditary fate to the vices of alcohol and adultery, and thus *East Lynne* was a ‘polemical literary text’ engaging with the degeneration debate.⁷⁹ Just as the novel’s heroine was propelled to a cruel fate of physical degeneration and periodic states of madness, Miss Beaton was engaging with a text in which mental illness was portrayed as the legacy of sin, a disease which crippled not only the mind but stigmatised the bodies of the insane. Penned by the middle-class author Mrs Ellen Wood, the novel portrays the fallen heroine’s father as an immoral and over indulgent aristocrat whose body was weakened by gout and his mind by intemperance. As the novel progresses, the declining moral and physical strength of the aristocratic father is passed on to his daughter, leaving her susceptible to vice. Born with beauty, kindness and innocence, she nonetheless fell from grace, seduced by a corrupt suitor. Having not been born with the moral strength to deny his advances, she lost her innocence, health and sanity from the moment she gave into temptation, being cast by Wood as ‘morally insane’. The fair body of Wood’s heroine grew pale and weak, while fever deprived her mind of clarity; and, as she rambled and raved, the author described the crippling effects of hereditary madness upon her body.⁸⁰

When authors such as Wood captured, modified and articulated notions of degeneracy within the nineteenth-century novel, such images of lunacy seeped into the cultural consciousness.⁸¹ Representations of the dishevelled melancholic, maniacal fools and verbose idiots populated such nineteenth-century texts, and therefore portrayals of the mentally ill as a physically stigmatised, atavistic class, became deeply entrenched within the culture of the Victorian and Edwardian eras.⁸² Miss Beaton’s narrative, informed by

⁷⁸ Elizabeth Jay ‘Introduction’ in Ellen Wood *East Lynne* (1861; repr. Oxford: Oxford University Press, 2005) p. XXXVI.

⁷⁹ Literary theorists who have studied this text are in general agreement that Wood was influenced by Benedict Morel’s theory of degeneration, see Andrew Maunder ‘“Stepchildren of Nature”: East Lynne and the Spectre of Female Degeneracy, 1860-1861’ in *Madness and Sensation* eds. Andrew Maunder and Grace Moore (Hampshire: Ashgate Publishing, 1998) p. 64.

⁸⁰ Wood *East Lynne*. Ssee also Maunder ‘Stepchildren of Nature’ p. 61.

⁸¹ Other examples of medical/scientific images of mental illness seeping into popular cultural mediums is Charlotte Bronte’s uptake of Victorian phrenology in *Jane Eyre*. Published in 1847, Bronte represented the human head and its cranial features as a surface of signs and symbols upon which the inner characteristics of her protagonists could be read. In a scene where Jane Eyre criticized the behaviour of Mr. Rochester, he defended his character by inviting Jane to judge his forehead. See Mary A Armstrong ‘Reading a Head, Jane Eyre, Phrenology, and the Homoerotics of Legibility’ *Victorian Literature and Culture* 33 (2005) 107-132.

⁸² Fifteen stage versions of *East Lynne* are said to have been performed by the end of the 19th century, with film adaptations appearing in the early 20th century starring Theda Bara in 1916, Alma Rubins in 1925

these images of the mentally ill, is arguably the projection of such an undesirable identity upon those who surrounded her. Yet it cannot escape notice that the identity of *East Lynne*'s fallen heroine offers a strange parallel to that of Miss Beaton. Both were defined as possessing charming mannerisms and yet hereditarily predisposed to mental disorder; both were rejected from society and consigned to the ranks of the morally insane. As the moralistic overtones expressed within *East Lynne* were still highly pervasive within the 1920s, kept alive not only by the psychiatric profession, but through literary, theatrical and cinematic productions, it is unsurprising that, as Miss Beaton entered the asylum, a patient identity, aligning her mind and body to such literary characters, was regarded with such fear and disdain.

Several weeks later and after several successful attempts to smuggle out letters, a letter arrived addressed to Dr Henderson, sent from Dr W. J. Beaton, Miss Beaton's elder brother. After some preliminary remarks thanking Henderson for helping his family in a time of such distress, he continued:

However, I feel that I must lose no further time in communicating with you as – apparently – my mother seems to be contemplating as the result of a letter of extreme plausibility that she has had smuggled out of the Asylum with the aid of a nurse; and I feel that my mother's life will not be safe if Margaret comes home, as her vindictiveness is so extreme that she is capable of anything, while at the same time she is so plausible and cunning that she is able to impress all strangers that she is a persecuted saint condemned to live in the midst of a family of criminals and savages.⁸³

Word by word, the published case history of Miss Beaton which first appeared in the 1927 *Text-book* under the chapter headed 'Mental Deficiency' reiterates this brother's statements. His letter was evidently held in high esteem by Henderson as a revelatory description of the moral defect within the domestic setting, and therefore well worth reproducing in detail, notwithstanding that the account echoes so closely the text from the *Text-Book* quoted on pp. 328-29 of this chapter (indeed the repetition is precisely the point). Dr Beaton's letter continued:

and a 'lavish American talkie' in 1935 starring Ann Harding and Clive Brook, see Jay's introduction to *East Lynne* p. XXXVI.

⁸³ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA.

Margaret is, if I remember, 23 years of age ; and I have seen little of her since she was 4 years old, and my parents from a sense of shame concealed her conduct from everybody. However I began to realise slowly what she was when I was home on leave (from France) in 1916 and 1917 visiting my father who was dying. She refused to sit by him when he was ill, refused to prepare food for him or to sit by him to relieve those who had been with him night and day, and jeered at the “constant morbid atmosphere of the sickroom” that pervaded the house. I begged my mother to have a nurse in the house, but neither nurse nor maid would they have for fear lest a stranger should talk outside the home about Margaret and her ways. She has terrorised the home for years, and driven more than one sister away from home by her threats and her violence. On my last leave before armistice she did not utter one word to me during the whole time I was in the house, and sat at the meals with her face turned the other way; when I left to return to the front I had to search her out to say goodbye, and my farewell met with no answer.

For years my mother has had to sleep at night with her bedroom door locked for fear of Margaret and her violence, and to have it locked by day to guard against thefts and indeed everything in the house is to be kept locked up. For weeks Margaret will not utter a word to her mother (except to demand money, or clothing – which she sells – with threats), and if mother comes near her she will go through the pantomime and sounds of vomiting. My youngest brother is an Engineering student at the University and is taking out his apprenticeship in Renfrew: when he comes home from the shipyard he has to stand over the water he heats to have his wash, because if he relaxes his vigilance for a moment, Margaret will take the warming water and pour it away down the sink. One day in midwinter she drew a bucket of cold water and deluged his hens (which were his hobby) “just to see what he would do”.

I am told that last year she was in a passion with mother and told her that she (Margaret) “would make her suffer”. She thereupon went through the house and crumpled every gas mantle into dust; lit all the gas jets of the gas stove and put over them every empty pot pan and kettle the stove would hold, and then slipped quietly out of the house and remained out until after dark.

... In my mothers last letter to me before Margaret came under your care she wrote (April 22) ; “I still have some coal and some wood but at the rate Margaret is using fuel ... it cannot last long – the waste of coal and gas is dreadful ... - she wastes it on purpose ‘to punish me’”. This was her behaviour during the coal strike!

It is painful to uncover the family skeleton like this, but you should know these details. Please prevent my mother if you can from running into danger by taking Margaret home; she is so plausible that while she is under your eye you will see little or nothing of all this.

Yours sincerely
W J Beaton (M.D.)⁸⁴

⁸⁴ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA.

Dr Beaton, who, after spending little time with his sister since she was four years of age, collated a chronological account of his sister's behaviour spanning the latter years of the First World War up until April 1921, when Glasgow's industrial heart steadily diminished in the wake of economic depression and the ensuing strikes of miners and dock labourers. Recalling his sister's 'jeer[ing]' at the morbid atmosphere of the sick room, and more generally terrorising the home, her actions evoked neither understanding nor empathy. Described by Dr Beaton as a plausible and cunning actress, his warning to Henderson that he would see little or nothing of his sister's petulant behaviour within the asylum drew a marked distinction between her behaviour in the family home and in public environments.

Noting his sister's seemingly nonchalant attitude towards the emotional strain and the financial burdens she placed on her family, Dr Beaton's remark that he began to realise 'slowly what she was' in the war years suggests he was writing, not only from a personal, but also a medical opinion. Faithfully constructing a picture of the 'moral imbecile' within such distinct settings and social encounters, his request to Henderson to retain his sister within the hospital follows the pessimistic outlook of late-Victorian practitioners such as Clouston. Dr Beaton's remark to Henderson that he was unveiling the 'family skeleton' is highly reminiscent of Clouston's text book description of the moral imbecile, regarded as the 'bane and disgrace of their families, and the skeletons in the closets of their relations ... [for whom] nothing can be made of most of them morally ...'⁸⁵ Since Miss Beaton's family had so ardently endeavoured to conceal their daughter's immoral behaviour from the world, there is the sense, in Dr Beaton's letter, that she was looked upon not only as an immediate threat to her family, but as a secret and a social disgrace. For practitioners such as Clouston who regarded moral imbecility as a hereditary disease, stemming from an inherent lack of a moral sense within the families of 'neurotics' and 'melancholics', then the stigma of degeneracy would indeed have been felt to sully the reputation of an entire family.⁸⁶

After receiving this letter from Dr Beaton, Henderson had a long conversation with Miss Beaton in which he told her that, contrary to his former intention to let her mother visit, he had now advised her mother to stay away. It was because of the letter that she had managed to smuggle out, Henderson stated, that he was now asking her mother to stay

⁸⁵ Clouston *Clinical Lectures* p. 373.

⁸⁶ D. K. Henderson and R. D. Gillespie *Text-Book of Psychiatry* (London: Oxford University Press, 1940) p. viii.

away from Gartnavel. Not wanting Miss Beaton's mother to feel prevailed upon to take her daughter away, Henderson stated plainly to Miss Beaton that she had not formed stable enough habits to warrant going home and that he feared some impulse might come to her, placing her mother in danger. Clearly influenced by Dr Beaton's letter, Henderson's reappraisal of Miss Beaton's case and, evidently, her entire case history was bound to this letter which fleshed out, so meticulously, the skeletal outline of her behaviour within the domestic sphere.

As the months passed Miss Beaton was noted to have behaved well, taking part in activities, reading, knitting and working in the laundry, generally in an amicable mood. Behind such outer expressions of placidity, however, Miss Beaton continued to write to her mother in a piteous and demonstrative tone. Small incidents began to arise, recognised by Gartnavel's medical officers as being demonstrative of abnormality; her refusal to wear new clothes and an attitude of 'ill usage' being noted in her case note records. As the length of Miss Beaton's confinement drew on, the expression of physical violation, so fervently voiced during her first weeks of confinement, turned to one of mental torment. In October, another letter was confiscated and retained within her case note records in which she wrote:

20th October 1921

Dear Mother,

Please come and see me if it's not too much to ask you. You must remember I am insane, so you shouldn't be so cruel as hardly ever to visit me in my imprisonment ...

I used to count the time here by hours – now I think it best not to count it at all ... I can't bear to let myself think because all my thoughts are outside this frightful place ... I try too not to absorb too much of what goes on here. You have put me in a very difficult position, and I will soon be as daft as you wish me to be.

As she spoke of being forced to absorb the hospital's surroundings into her mental consciousness, the style and the content of her narrative changed from one professing sanity to one almost claustrophobic in its expression of mental torment. She sarcastically relinquished her claim to sanity, but through the expression of rebellion and aggression. Endeavouring not to think, and not to absorb the goings-on of the hospital environment, it was she, not the medical profession, who was going to control her mind. In threatening to numb her emotions and deaden her intellect, she sought to make herself impervious to

medical treatment.⁸⁷ Such a tactic, as Erving Goffman's seminal texts on *Asylums* argues, reflects the status of a patient for whom 'objects of self feeling', such as their 'bodies', 'thoughts and ... possessions' were formerly kept 'clear of contact with alien and contaminating things', but for whom the hospital environment caused 'these territories of the self [to be] violated'. [T]he boundary that the individual places between his being and the environment', asserted Goffman, being forcefully 'invaded'.⁸⁸

Over the next few years Miss Beaton's records did not retain any of her correspondence. Rather, they reveal the steady deterioration of her behaviour, periodically escalating to fits of violence and destruction. Early on in her confinement, she came into collision with some of the other women on the ward; and, after initially requesting to be moved to another part of the hospital, the next few years saw her being removed from one ward to another, each time colliding with a new set of patients. Her 'spiteful' attitude being noted as the cause of the disturbance. Such acts, it was reported in March 1922, were always done 'on the sly' and were therefore difficult to 'proof' (sic) but, with many patients complaining about her behaviour, she was soon considered to be the one in the wrong. She also began to cross the nursing staff, it being reported that, while attempting to sell her clothes to the nurses on her ward, she was simultaneously complaining that her garments were disappearing.

Throughout her first year of confinement, Miss Beaton was offered ample opportunity to engage in a variety of activities, but she 'refused' 'sullenly' to take part in anything. In April 1922 Miss Beaton's mother cut her ties with Scotland and moved down to Manchester to live with one of her sons, and it was because of this move, the reporting medical officer surmised, that Miss Beaton fell into a difficult, irritable state. 'Not unnaturally', continued the report, Miss Beaton felt that she would be more 'isolated', 'ill used and neglected' than ever before. Her bitterness was expressed in fits of rage as she smashed vases and attacked the furniture. After it was decided that Miss Beaton be moved back to the infirmary ward where she could be under a higher degree of supervision, she

⁸⁷ Within wider academic work on patient narratives, the work of Allan Beveridge has revealed a number of patient's letters, which speak of their resistance to the mind numbing effects of the asylum routine. A letter which was written by a patient from within the Royal Edinburgh Asylum in 1898 stated 'I feel I cannot stand this place a minute longer and soon I shall lose the brains I had, and not be able to interest myself in others and everything that goes on in the world. The monotony and routine simply drives me wild...I feel I shall go on degenerating in this environment into an animal'. Allan Beveridge 'Life in the Asylum: Patient's letters from Morningside, 1873-1908' *History of Psychiatry* IX (1998) 431-469 p. 431.

⁸⁸ Goffman *Asylums* p. 31. See also Piddock *A Space of Their Own*.

refused to go and began once more to destroy items of furniture and attack other patients. Over a year after she was first admitted, sedatives were first recorded being used as a means of constraint. Because she refused to lie in bed and take her food, further mechanisms of restraint were applied by physicians and nursing staff, and she was forcefully induced to undergo tube feeding.

A year later in 1923 Miss Beaton was still noted to be unstable in her temperament, but her irritability had somewhat abated. By August she had attained parole and could wander freely in the grounds, to play tennis and golf, and by March 1924 it was reported that she had gotten over her 'queer turn' and had 'really behaved herself very well'. The nursing staff still occasionally noted small incidents where she upset other patients, as when she accused a number of ladies of being syphilitic, but on the whole she was enjoying the entertainments and her parole was extended so that she was allowed into town with a nurse. After this prolonged period of good behaviour Miss Beaton confronted Dr Henderson and asked him why she was still being held within the hospital, demanding to know "what was he doing about it." Dr Henderson replied that it was on account of her behaviour at home that she was in Gartnavel and that it was therefore 'up to her people to decide whether they could come for her'.⁸⁹ To this response Miss Beaton became irate, accusing Dr Henderson of keeping her 'for spite and nothing else'.

Henderson's remark seems to be out of place with the philosophy of Gartnavel, as the institution's annual reports emphasised the hospital's curative function, while simultaneously discrediting accusations that it was a place of detention. Commissioner Mr J. A. Roxburgh, LL.D wrote in the Annual Report in 1925 that '... ever since he had anything to do with the Institution, [he] had always had in view that it was a place for cure, not a place for detention'. Exceptions, conceded Roxburgh, were sometimes made as '[t]here were certain cases which must be detained but the Directors endeavoured in every way they could to put into operation what they believed, namely, that the object of the Institution was to try and cure people, and not simply detain them'.⁹⁰ By the standards set forth here, Miss Beaton's case must have been one of the few exemptions in which detention was justified. Her release, according to Dr Henderson's own admission, was based, not only upon a set of medical criteria, but upon the wishes of her family, including

⁸⁹ New Case Book Series: Females, Vol 28, GB812 HB13/5/176 NHSGGCA.

⁹⁰ *The One Hundred and Twelfth Annual Report of the Glasgow Royal Asylum for the Year 1925* GB812 HB13/2/112, NHSGGCA p. 5-6.

their ability and willingness to reabsorb her within the domestic circle. As her case demonstrates the power held by the family in cases such as these, it also highlights the ambivalent legal, social and medical status possessed by Miss Beaton. Since she posed as much a social as a medical problem, Henderson was later to write in his 1927 *Text-book* that the ‘so-called “moral imbeciles”’ could not be dealt with by the psychiatric profession alone. Instead, it was a matter for the ‘teacher, the social worker, the parent, and the law’ because the moral imbecile did ‘more damage in a community than any other type’. Because their defect was so slight, Henderson argued that they could often maintain themselves within society and yet were unable to ‘exercise self-control and ordinary decency’. Therefore the question of their management was a matter to be tackled by entire communities and a network of professional organisations. The education of the public, argued Henderson, was of vital importance; ‘only by giving the public the facts, and teaching them to think in a commonsense way’ could the problem of the ‘so called’ moral imbecile be dealt with humanely.⁹¹ This common sense approach to the care and treatment of patients such as Miss M.B. clearly upheld the Meyerian approach, defining mental illness as a social as much as a biological problem. But set within 1920’s Scotland - where mental hospitals were still largely alienated from the rest of the medical profession and where the integration of social services into the psychiatric community was still largely in its infancy - Miss Beaton’s case demonstrates how these environmental conditions undermined the psychiatric profession’s ability to treat such cases, necessitating the complete removal of the ‘moral imbecile’ from family, friends and society.

A letter written by Miss Beaton several months after this conversation with Dr Henderson demonstrates that, although outwardly she blamed Dr Henderson for keeping her within the hospital ‘for spite’, she was very well aware of the role played by her family members in maintaining her confinement.⁹² On the 21st May 1924, she wrote:

My dear Mother

Thank you ever so much for the lovely costume you sent me – but it is a Summery one. I couldn’t possibly wear it every day, it is too good. Is a little waistcoat not meant to be worn with it – it is so open at front? ... I give the impression, when I have on my “finery” that I have seen better days! However I know I will never see any better than these it seems, but it doesn’t matter very much if you don’t mind.

I hear that W. is coming up here sometime – is it as a patient he is coming at last?

⁹¹ Henderson and Gillespie *Text-Book of Psychiatry* (1927) pp. 38-39.

⁹² New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA.

Thought it would come to that sooner or later but is there not a nearer place to Manchester than this that he could be put (I hardly like the disgrace of it!) It is a pity for him too, but he is better “put away” if he is too much trouble to manage at home. Perhaps he is just coming to consult the doctor about his mental condition this time, but would it not be safer if somebody else were with him? It is taking a grave risk to let him come alone. If he intends to see me at the same time, he need not do so, for I do not wish to see him, in fact, I wish to have no dealings with him whatever.

He is taking far too much upon himself if he thinks that he can or has the right to decide my fate or my future. Has he been legally constituted my guardian I would very much like to know? ...

Do you really prefer me to be here? Heaven only knows why if you do. Is it really cheaper to have me here? ... One would have to be either a saint or a devil to get on at all without bad effect on one in this place. ...

There is a lady patient. A Miss Barrhead – who ... knows Aunt very well ... she is an awful chatterbox – I have got more news from her about the family (she knows all about us) than I have got from the family itself for years...Both [name of medical sister] and [name of medical brother] should remember that charity begins at home. I am insane or supposed to be and am not expected to know that – but they have no excuse. With much love and thanking you again for the costume and hat you sent –
Your loving daughter

Margaret⁹³

Laden with sarcasm and mimicry, her portrayal of her brother as a disgrace, a danger and a burden to the family, was clearly expressive of her resentment at her own treatment. Through the imaginary reversal of roles, she highlighted the absurdity and the injustice of her medical brother having the power to decide her fate, given that he too was recognised as being disposed to eccentricity. As she bemoaned the trouble that her brother brought upon the family, and the disgrace of having him ‘put away’ in such close vicinity to herself, she exposed how own feelings of alienation, abandonment and rejection. Her dress, her reputation and her entire identity, she argued, was no longer under her own control. With her new clothes being regarded as a costume, a theatrical cloak of ‘finery’, the role of the ‘insane’ woman, she seemingly intimated, was steadily shrouding her identity.

Segregation and manipulation

Over the next few weeks, Miss Beaton’s records continued to highlight her good behaviour, but striking ‘abnormalities’ in her conduct towards other patients were also noted. ‘Without provocation’ she said to one patient on the female ward, “Don’t look at me you common woman ... You could only earn £1 a week as a shop girl ... You common

⁹³ Ibid.

guttersnipe!” A month later she was caught slyly sticking a pin into another lady who resided within the ward, again seemingly without provocation. Such divergence in her behaviour, between her outer, sociable nature and her more underhand acts of malice, were repeatedly highlighted in her case notes.

By the end of May, an incident occurred in which contradictory aspects of her characteristics were starkly illustrated. Partly on account of the amorous attentions of one of the male patients, courting her as they strolled together through the gardens, Miss Beaton’s parole within the grounds was stopped. Confined within the building, it was noted by Henderson that Miss Beaton began to address him with a degree of civility which, he reported, was a complete reversal from her usual blunt, ‘even rude’ manner. She asked Dr Henderson ‘very sweetly whether she couldn’t get her parole back’, in a manner which, Henderson recorded, was ‘wheedling’. The reinstatement of her parole was declined. A day later, one of the hospital’s medical officers wrote that when examining a newly admitted patient - behind ‘the screens [and] engaged in conversation’ - Miss Beaton had drawn back the curtains and ‘with a rather blushing countenance’ inquired whether she could be given a ‘slip’ so that she could go to the Occupation Department. The medical officer wrote that, ‘at some slight inconvenience, an inconvenience of which Miss Beaton was probably aware’, he went downstairs to procure the paperwork. As soon as he had completed the slip, a ward sister came to say that Miss Beaton was no longer willing to go to the class and that, in the medical officer’s absence, she had slapped one of the depressed patients who resided on the ward. ‘The whole affair is interesting’, reported the medical officer:

... because Miss Beaton has never made any attempt to go to the Occupation Class all the time she was on parole; that as soon as her request was granted she would not go. The writer was left with the impression, - which may be wrong of course - that the asking to go to the O.D. was more or less in the nature of a “try on”, that if the request had been refused then she wd have had a legitimate grievance, - she was not allowed to go to the class etc etc. The striking of the patient seems in the nature of a reaction when the plan did not succeed; and it was certainly without legitimate or reasonable excuse.⁹⁴

The medical officer formed the opinion that Miss Beaton was endeavouring to manipulate those around her, reflecting observations made by early 20th-century eugenicists such as

⁹⁴ Ibid p. 598.

Talbot, who described the morally deficient as a class of person who ‘manipulated and coerced those around them’. Indeed, Henderson’s earlier observation that Miss Beaton’s manner was ‘wheedling’ and unusually ‘sweet’ reflects Talbot’s opinion that such individuals could be ‘sycophantic to the point of nauseousness in their deportment towards those from whom ... favours are to come’. Only once observed over time was it considered that their true self became visible, their abnormalities rising to the surface as they interacted with those around them.⁹⁵ Miss Beaton’s case note records evidence the slow, yet steady process by which psychiatrists ‘unearthed the undercurrent of perverted mental action’ which was seen to lie deep within her character.

Several months later, Miss Beaton’s medical brother, Dr Beaton came up from Manchester. On his arrival to the hospital, he entered into conversation with Henderson, eventually broaching the subject of his sister’s future. He told Henderson that he feared his sister to pose a danger to the safety of the family. It was recorded that she had reportedly ‘threatened, whenever she obtained her discharge from here, to murder himself, and certain members of the family, and she also stated that if such things did happen she would probably be held to be irresponsible’.⁹⁶ Having had her liberty taken away by her family, Miss Beaton, it seems, found recourse to assume the identity of the insane in order to reinstate a degree of power over her family. Reading between the lines of her statement that ‘*I am insane or supposed to be and am not expected to know that*’, the seeming ambivalence and contradictory nature of such a declaration thinly veils a deeper, critical, almost threatening awareness that, while such an identity negated the validity of her thoughts and statements, her actions were absolved of responsibility or legal punishment.⁹⁷ After this interview between Dr Beaton and Henderson came to a close, the former followed a medical officer upstairs, where his sister was to be found. The medical officer addressed Miss Beaton: “your brother, Dr W. Beaton, is here, if you care to see him”, “I do not care to see him”, she replied, before she ‘shut the door in the face of the Nurse’ and the escorting medical officer. Her expression was noted to be ‘of extreme and bitter antagonism’.⁹⁸

After this incident, her records lay largely untouched until April of the following year. With her parole having been withheld throughout this period, she was noted to have

⁹⁵ Talbot *Degeneracy* pp. 315-329.

⁹⁶ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA.

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

become extremely abusive towards other patients and destructive to the hospital's interior. At times she was observed to be in a restless and excitable mood, and gradually she began a somewhat irregular routine of protest. Rather than plead or cajole the medical officers into giving her back her parole, she passively refused to cooperate with hospital regulations. Thus:

13/4/25 Since last reported. Miss Beaton has been quiet. She shut herself in her room and has remained there most of the time.

17/4/25 Miss Beaton has been quieter since last reported ... She refused, however, an open offer to re-tell her whole story from the beginning, saying that it was of no interest to the M.O. All attempts at reasoning was futile [sic] and the only positive statement she would make was "What I need is fresh air – I must have it and I want my parole – until I get that I won't take any food". In spite of this, however, she continues to take her meals ... Last night she again entered Mrs. Cairn's room and was abusive to that harmless old lady. She did not attempt any violence...

27/4/25 Miss Beaton appears to be in good physical health. She refuses to put on her clothes until given parole.

30/4/25 Miss Beaton has put on her clothes these last two days. She continues to ask for parole.⁹⁹

It is telling to recollect Henderson's remark in the *Text-book* that, 'if a patient is allowed to tell his story ... from the beginning ... and with a minimum of questioning', this process produces 'gratitude, and establishes confidence' between the patient and practitioner.¹⁰⁰ As the patient's confidence was won over and they confessed their life histories, this act, argued Henderson, 'prepared the ground' so that the physician could 'persuade' the patient to be a 'useful, if still not at all normal, member of society'.¹⁰¹ Without this bond of trust being retained, Miss Beaton denied Henderson access to her life history; and, in refusing to re-tell her 'whole story from the beginning', she deprived him of the dialogue that was so central to his psychobiological methods. Instead, her attentions turned inwards, towards her body. After her verbal pleas for the reinstatement of her parole failed, she locked herself away, stripped away her 'costume', her 'finery', and resisted the intake of food.

After Miss Beaton wrote to the Board of Control in June, this coincided with the reinstatement of her parole, and the next eight months were later remarked upon as a 'spell of good behaviour'. It is nonetheless clear that Miss Beaton was still harbouring a great

⁹⁹ Ibid

¹⁰⁰ Henderson and Gillespie *Text-Book of Psychiatry* (1927) p. 74.

¹⁰¹ Ibid p. 266.

deal of resentment against Henderson and was coming into conflict with the nursing staff. On the 28th July 1925, Miss Beaton wrote to Henderson:

1055 Gt Western Road
Glasgow
July 28th 1925

Dr Henderson

I understand that the Sunday before last when nurse White was charge in this ward there was a very false report given about me. Nurse White said that I was “irritable, and noisy, and using very foul language, and threatening the nurse”. I certainly scolded nurse White very severely and checked her for taking God’s name in vain – a great many of the nurses take God’s name into every second sentence in a most profane way, and I will check them for it. She flew into a temper. Said I was only a patient and would not check her again, and she would take God’s name in vain if she liked. And I would get into trouble – she would see to that. She also said to one of the patients that she wished I would attack her so that she might report it. As I did not nor had any intention of doing so she tried to injure me by a lying report.

... I never use foul language and I wont have my character besmirched in such a way by spiteful, ignorant and profane nurses ... It is their only means of revenge when I tell them what they should not do ... It is their threat to me because they know you believe them and sign your name to their written lies... Please why do you allow the nurses – if you know – to tell so many lies about the patients and to injure their characters, and believe them just because their lies are in writing and even though they are Roman Catholics who do not consider a lie a sin? ...

I think it would be advisable that when you hear of your respectable patients using “foul language” you should make a few inquiries before you sign your name to the report.

M. Beaton

Here Miss Beaton spoke of the imbalance of power between patients and nursing staff, bemoaning the authority that nurses held on the ward and the system by which doctors verified nursing staffs’ statements. Language and the written word are here presented by Miss Beaton as a source of inequality. As the day-to-day activities and utterances of patients were inscribed in nurses’ reports, institutional representations of the truth clearly weighed heavier than her own. The following case note record demonstrates, however, that Miss Beaton could circumvent, if only temporarily, the power and authority of the medical ‘gaze’ and the knowledge that it produced.

Setting the stage

27th February 1926

Last night the M.O. paid his ward visit at 9.30 PM and was told that a few minutes previously Miss Beaton had come to report a headache to the nurse in charge, she had asked for a powder and then, without more ado had swept... various books off a table, knocked the table over and broken some crockery.

The M.O. went to see her found her angry and uncommunicative ordered aspirin gr x and gave instructions that her door should be locked.

Half an hour later he was again called to the ward, the lock having proved defective and Miss Beaton was [illegible] out and throwing chairs about, assaulting the nurses when they tried to get her back to her room. The M.O. ordered her removal to another room with a sound lock... Half an hour later the M.O. was informed that Miss Beaton was shouting that she would be found a corpse in the morning, and considering that she was in such a state of rage that she would do anything which might in anyway injure the staff he decided to give her a hypo.¹⁰² On approaching her room everything was silent. On opening the door she was seen, with the bed drawn across the room so that it was the first object noticed on opening the door and could if necessary have been seen from the keyhole, lying motionless a ribbon from her underwear tied round the bed rail but with her chin merely resting in the loop. In the dim light it looked like an attempted suicide, but in point of fact it was merely a simulated suicide, the loop being quite loose and the force of it applied to her chin ...

13th March 1926

Since the last note Miss Beaton has been secluded constantly. She strikes the nurses who attend her, attempts to bite them and at times spits at them ... last night she was found with a towel loosely tied round her neck and fastened to the bed rail. The observation window she had covered with a piece of paper. This was probably another case of feigned insanity.¹⁰³

As Miss Beaton's suicidal performances were judged as 'another case of feigned insanity' this entry begs the question of whether this claim was a mere slip of the tongue or whether the medical practitioner genuinely saw Miss Beaton's performance as an enactment, rather than evidence, of insanity. Clearly, both patient and practitioners were locked in a theatrical performance, a dramatized struggle for power and dominance, as they used the hospital environment to control and coerce one another.

¹⁰² The term 'hypo' refers to the injection of a sedative.

¹⁰³ New Case Book Series: Females, Vol 28 GB812 HB13/5/176 NHSGGCA pp. 608-609.

The landscape of the hospital building - combined with the disciplinary regimes of attendants, mechanisms of restraint and sedatives - controlled patient bodies and, to differing degrees, their minds. But as Miss Beaton's case notes suggest, patients could, and did, hold the ability to undermine the asylum regime. As Davies states, 'patients are never merely subject to or constituted by the ... medical gaze', but rather, 'the gaze is both mediated and reciprocal, and therefore patients have frequently been able to manipulate the gaze for their own purposes'.¹⁰⁴ Miss Beaton's suicidal performances momentarily reversed the flow of power between patient and medical staff, and the power of observation, held by the asylum's nursing staff and medical officers, was in part undermined by Miss Beaton as the dim light of the room, coupled with the fixed position of the observation window, enabled her to control the view of the interior. From outside of Miss Beaton's single room, the nurse's view was static, only allowing a frontal inspection of the room's interior; but, like that of an audience watching a theatrical performance, barriers separated the observer from immediately appreciating that the scene was one of illusion rather than reality. Because Miss Beaton felt her words were powerless within the hospital environment, it is arguable that she turned to her body in order to speak. Acts of violence, unlike the spoken or written word, would presumably be observed and acted upon.

Faces and spaces of lunacy

After Miss Beaton had spent almost five years in Gartnavel, her case note records concluded that her behaviour had grown uncontrollably violent. After the simulated suicide, she was judged to threaten the safety of patients and nursing staff, and was transferred from an open plan dormitory on the first floor to a ward several floors higher within the building where she was locked in a single room. This ward was reserved for the more disturbed, unmanageable class of patient and was referred to by Miss Beaton as the refractory ward. As she repeatedly assaulted the ward nurses by spitting food in their faces, and as she threw chamber pots out of the window, smashed crockery to the floor, and refused to leave her room or associate with the other patients on the ward, she came to be known by the hospital Commissioners as the one anomaly who marred an otherwise

¹⁰⁴ Davies 'A Small Corner that's for Myself' p. 313.

unblemished record of non-restraint.¹⁰⁵ In the Annual Report for the year 1926, Commissioner Marr wrote in his report that:

... in the register of Restraint and Seclusion there were 90 entries. These had reference to 2 female patients, one of whom was registered as being in seclusion in the majority of the 90 occasions recorded. This patient was seen; she is very difficult to deal with and very unreasonable in her demands, in her assertions and in her conduct. When seen she refused to speak. She was occupying a room which was quite open and free for her to walk out and in. When she was left after the interview she came and slammed the door, thus putting herself voluntarily in seclusion.¹⁰⁶

For a year Miss Beaton had remained, sometimes voluntarily, sometimes by force, under seclusion in her single room. In the *Annual Report* for the year 1927, she was again singled out as the one troublesome anomaly:

A large number of entries, ninety-eight, in the Register of Restraint and Seclusion refer to one female patient whose impulsive conduct was referred to in the previous report... It is noted that, except in the case of the female patient already mentioned, there are no locked doors, either of dormitory or bedroom, during the night, throughout the Institution, and that no patient who requires special observation occupies a bedroom unless with a special nurse in attendance.¹⁰⁷

Such reports highlighted the extreme difficulties of management posed by Miss Beaton. As her behaviour necessitated that mechanisms of restraint, segregation and observation were continually imposed upon her, such records do much to reveal the formation of Miss Beaton's patient identity, but they fail to explore the driving force behind her actions. They do little to reveal why her behaviour escalated to such violent and disruptive proportions, nor do they explore the meaning, ascribed by Miss Beaton, to such events. The following letters, written by Miss Beaton after she had spent over a year in isolation, enable an alternative history to be told.

¹⁰⁵ Following the Lunacy Act of 1857 a General board of lunacy was established, which appointed Lunacy Commissioners to oversee the conditions of all insane persons in the UK. See Ezra Susser, Joy Noel Baumgartner et al 'Commentary: Sir Arthur Mitchell – Pioneer of Psychiatric Epidemiology and of Community Care' *International Journal of Epidemiology* 39 (2010) 1417-1425.

¹⁰⁶ *The One Hundred and Thirteenth Annual Report of the Glasgow Royal Asylum for the Year 1926* GB812 HB13/2/113 NHSGGCA p. 57.

¹⁰⁷ *The One Hundred and Fourteenth Annual Report of the Glasgow Royal Asylum for the Year 1927* GB812 HB13/2/114 NHSGGCA.

Tuesday 1st February 1927

Dr Henderson

Will you not let me go back to ward I now please? This is torment to me.

Place is everything to one highly strung as I am, and to most people who are acutely sensitive and impressionable to surroundings (symptoms perhaps) – unless of course they are a Daniel who remained unscathed when thrown into a den of lions, or the three Biblical men who were unburnt and unharmed when they were cast into the fiery furnace – but unfortunately I am made from different stuff from these...

I have written to my brother and have asked him if he will pay a little more for me to enable me to have a room in ward I _ he could do it quite well, but as I have had no reply so far I am thinking my letter has not been sent...¹⁰⁸

This letter demonstrates Davis' observation that, as patient narratives are often framed by the 'use and interpretation of space', they offer researchers 'alternative ways of marking, naming and mapping hospital spaces'.¹⁰⁹ Miss Beaton argued that the physical confines in which she was placed intensified her illness, exemplifying how 'Place' apparently played an integral role in the formation of her personal identity. Her analogous description of the ward as a den of lions, or a fiery furnace, implies that this environment may be explored, not only as a space of confinement and control, but as a place upon which emotions could be projected and bodily sensations affected. Indeed, as the fierce, fiery aura of the ward was said to enflame her emotions, boundaries between her physical environment, her body and her internal sense of health and self became inextricably blurred, and it is therefore to this phenomenological construction, indeed, conflation of space, identity and illness, that analysis will turn. In the following letters, written several days later, her most poignant and revelatory description of the ward emerged:

Dr Henderson

4th February 1927

Some years ago when my sister was a medical student ... and we were staying in Edinburgh for a holiday she was very anxious to see over the medical museum there and she went there one day and took me for company. It was all so abhorrent to me that I kept my eyes shut most of the time – but there was one thing that particularly impressed and nauseated me. It was a group of wax heads of a family of mentally afflicted persons of different types. While my sister positively gloated (from a technical point of view) over these I was sick and felt very ill and actually could not sleep for nights as a consequence. All the following night I was haunted by these faces. The shapes and expressions of them (although they were dumb) and tried hard to think of Princes St gardens and the bright shops and anything beautiful to drive out

¹⁰⁸New Case Book Series: Females, Vol 29 GB812 HB13/5/177.

¹⁰⁹Davies 'A Small Corner that's for Myself' p. 316.

the horrible thoughts that had arisen from what I had seen but it was no good – they predominated over everything. I had bad dreams for a long time after that, and even during the day I could not rid my mind of them. Perhaps that gives you a little idea of what this is to me. I have to live beside the embodiment of insanity of the worst kind and listen to them all day and at night too and every night. Fortunately I do not see them, being in this room, but I hear them all the time and know I can't get away from them and am said to be one of them myself. ...The spirits of all the insane people that I have seen in this room, and who have been in this room that I have not seen, permeate it – the walls, the ceiling, the floor and the bed and every cubic inch of the atmosphere I breathe. I feel as if it were pressing on me on all sides and every minute of the time when I was in this room before is ever present with me ...

This illness is not due to either hereditary or disease, so it must be due to present environment. It is; and will you not change it for me please? ... the moment I entered the ward I was dragged down by something indefinable and have been kept in the grasp of it ever since. Please will you let me go back to ward [I] again ...¹¹⁰

Margaret Beaton

Miss Beaton here defined insanity as not only an illness afflicting minds and bodies, but as something of an independent entity, a pollutant and a source of corruption which permeated the walls, the ceiling and 'every cubic inch of the atmosphere' which she breathed. From the confines of her single room in the upper wards of the hospital, the presence of insanity, she argued, was inescapable. Categorically placed among a class of patient whom she regarded as the 'embodiment of insanity', Miss Beaton insisted that it was the environment of the ward, not heredity, nor disease, which was the cause of her illness. If only she were to be removed from such a corrupting space, and placed downstairs within ward I, then, she impressed upon Dr Henderson, could she recover. Yet it is clear that, while such 'embodiments of insanity' were felt to pervade the ward, her portrayal of insanity originated from outside of her tangible surroundings. As the sounds of the patients who populated the ward encroached upon her mind, it was the image of the waxen faces, which had so horrified and nauseated her at the medical museum, that permeated her imagination.

For present day psychiatrists such as Theodore Millon who engages with the narratives of individuals recognised to possess pathological personalities, the sheer weight of emotion held in such a letter may be understood to reflect the 'unusual vulnerability' and fragility of such individuals under conditions of subjective stress. As distinct points in time and

¹¹⁰ Letter written by Miss Margaret Beaton on the 8th February 1927, retained in a folder containing letters from numerous patients which were written within the 1920s. GB812 HB13/11/2 NHSGGCA.

space conflate in her story, the layering of memory and meaning reflects Millon’s contention that painful, hidden memories often surge to the forefront of the ‘psychopath’s consciousness’, ones that ‘override present realities, and become the prime stimulus to which the individual responds’.¹¹¹ While Miss Beaton barricaded herself away from ‘embodiments of insanity’ she envisaged to populate the refractory ward, the intensity of past memories and emotions became imprinted upon the written page, as she spoke of the slow permeation of the sounds, spirits and memories of the insane pressing upon her, dragging her down to the depths of illness.

I argue that the sheer weight of emotional distress held within her narrative may be further comprehended if we, as historical researchers, begin to recover such memories and imaginings. If we let ourselves become engrossed in the field of analysis, to imagine ourselves within the anatomical museum, gazing into such faces of insanity, then I argue, in accordance with Owain Jones, that we may begin to comprehend how these felt moments became ingrained with Miss Beaton’s mind and body.¹¹²



Figure 16. Photographs of the Hillings plaster casts, objects held by the National Galleries of Scotland, Ref, PGL 2199, PGL 2200, PGL 2201. Printed with the kind permission of the Collection of the University of Edinburgh.¹¹³

¹¹¹ Millon *Disorders of Personality DSM III Axis II* pp. 10-11.

¹¹² Owain Jones argues in ‘An Ecology of Emotion, Memory, Self and Landscape’ in *Emotional Geographies* eds. Joyce Davidson, Liz Bondi, Mick Smith (Hampshire: Ashgate Publishing Ltd, 2007) p. 208 that; ‘Each spatialized, felt, moment or sequence of the now – being – laid – down is, (more or less) mapped into our bodies and minds to become a vast store of past geographies which shape who we are and the ongoing process of life’.

¹¹³ Photographs of the Hillings Plaster Casts PGL 2199, PGL 2200, PGL 2201 National Galleries of Scotland. Printed with the kind permission of the Collection of the University of Edinburgh. Photographer Hazel Morrison.

Museums of madness, faces of lunacy

To step into Edinburgh University's Anatomical Museum at the turn of the twentieth-century, would be to face an eclectic assortment of physical specimens, with skeletal remains, organs, plaster casts and wax moulages displaying the pathologies of illness and disease to academic and educated visitors. To peer at human tissues, suspended in yellowing preservation fluids or to gaze at a network of wax arteries and veins, was to view a muted, static representation of the human body. Free from pulsations, odours, sounds and movement, museum objects largely removed the onlooker from the sensual, living experience of illness and disease, and yet there were objects within medical museums that bridged the distinction between life and death.¹¹⁴ In the late-1910s and 1920s, a collection of life and death masks lined the museums shelves and display cabinets. Placed high upon their pedestals were casts of the heads of criminals, nobles, geniuses and, most notably the 'insane', whose faces correlate most closely to that described by Miss Beaton.¹¹⁵ Among this phrenological collection, a set of casts named 'The Hillings's family of idiots' offer a distinct, yet intertwining history of mental deficiency which spans the nineteenth and twentieth centuries.

Cast by the sculptor A. L. Vago in his London workshop in the second half of the nineteenth century, the Hillings casts were used to demonstrate the condition of microcephalus to medical students and educated visitors. Characterised by their "sugar-loaf" shaped skulls, rapidly receding foreheads, beak-shaped noses and receding chins, these cranial casts are replicas of an original set produced in 1827 for the famed phrenologist Dr Johanne Spurzheim. Used to teach their viewers to read, on the surface of the body, the tell-tale signs of mental deficiency, they upheld Victorian notions of

¹¹⁴ Steve Sturdy 'Making Sense in the Pathology Museum' in *Anatomy Acts: How We Come to Know Ourselves* eds. Andrew Patrizio and Dawn Kemp (Edinburgh: Birlinn, 2006) pp. 109, 114.

¹¹⁵ To give an example of the objects in the collection there was a 'Cast of Head and Neck of a Microcephalic Idiot Known in Edinburgh as "Bobby Awl"' Catalogue No N. A. f. 4. (1996) 'Cast of Macroglossia Enlargement and prolapsus of the tongue ... Three wax casts shew respectively the condition of the tongue before treatment, and a fortnight and three months after treatment...' Catalogue No. A1. A 1, 2 and 3 (914a, 915, 916) 'Brain of a microcephalic idiot, who died, *aet* 32, in an epileptic fit through impaction of a piece of gristle in the windpipe. Presented by Dr Wilkie Burnam [of Wilts County Asylum]' Catalogue No. N. A. f. 13 *Catalogue of the Specimens in the Anatomical Museum of the University of Edinburgh Vol. 1 – PATHOLOGY* – (Edinburgh: James Thin, 55 South Bridge, 1909).

hereditary degeneracy.¹¹⁶ Scholarly text books published as late as the 1920s described the Hillings casts as a set of specimens demonstrating the physical features of a degenerative, animalistic, characterless set of creatures for whom ‘coarseness, crudeness and abomination [were] written in every line ... form and ... feature’. The intersection of medical science with artistic technologies produced objects that functioned not only to replicate the outer protrusions of a biology entity, but also to buttress an array of moral judgements.¹¹⁷

Defined as a form of mental deficiency, microcephalus was therefore connected to moral deficiency through their shared meta-categorisation. Indeed, in Henderson and Gillespie’s *Text-book* (1927), the case history of Miss M.B. was classified alongside cases of microcephalus, kleptomania, eccentricity and idiocy, and therefore Miss Beaton’s medical identity was directly aligned to the motionless faces that sat, eyes tightly shut, raised upon their pedestals.¹¹⁸ It can only be surmised whether this collection of cranial casts was the one encountered by Miss Beaton as she followed her sister, eyes lowered, through an Edinburgh medical museum, but if we let ourselves be guided by the atmospheres, experiences, objects and sensations which linger around these historical spaces and centuries old faces, such material artefacts may tell us something of the phenomenological experiences captured in her narrative.¹¹⁹

¹¹⁶ In 1827, Mrs Sukey Hillings was described as an idiot from Beccles Suffolk who was ‘frequently intoxicated’ but who had ‘sufficient locality to wander from home in the fields and find her way back’. It was recorded that she submitted to have her cast taken ‘on receipt of a gaudy-colored shawl’, and that after receiving this token, she was taken to a sculptor’s studio, her face was cleansed, layers of oils and waxes applied to her skin and hair and two small quills were then inserted up her nostrils to allow her to breathe, if somewhat uncomfortably, throughout the casting process. Cotton threads were then placed across her forehead before strips of muslin, soaked in plaster, were smoothed over her face with additional layers of plaster being coated on top to create a durable plaster negative. Once dried, the plaster was carefully removed from her face and the sculptor set to the task of pouring a preparation of plaster into the negative. After this had dried and the negative removed, this delicate and highly skilled process reproduced a detailed, three-dimensional bust that reproduced down to the individual eyelash, a portrait of the sitter. Coloured waxes offered an alternative medium which, when poured into the plaster negatives were adorned with glass eyes, human hair and painted with flesh like tones. As organs, skin diseases, and entire anatomical models could be produced in his fashion, they were unnerving in their close to proximity to reality. See L. Hamilton McCormick *Characterology, an Exact Science* (Chicago: Rand McNaley and Co, 1920) pp. 637-8 also Plate 65 and 66. Also see J. B. S. Jackson *A Descriptive Catalogue of the Warren Anatomical Museum* (Boston: Williams and Co, 1870) [googlebooks.com] accessed September 2012 p. 46. Details of the casting process can be found in Anon, *Death Masks and Life Masks of the Famous and Infamous, from the Collection in the University of Edinburgh’s Department of Anatomy* (Edinburgh: University of Edinburgh, 1988) p. 41.

¹¹⁷ McCormick *Characterology* p. 636-7. See also Thomas Schnalke *Diseases in Wax, The History of the Medical Moulage* eds. T. S. Spatschek (Singapore: Toppan Printing, 1995).

¹¹⁸ Henderson and Gillespie *Text-Book of Psychiatry* (1927) pp. 376-387.

¹¹⁹ After researching the collection of Edinburgh’s Anatomical Museum and The Medical Museum of Edinburgh’s Royal College of Physicians and Surgeons, the anatomical museum’s collection of life and death masks matched most closely the objects described by Miss Beaton. Although this collection of

Replication of emotion, internalisation of the medical gaze

From the moment these plaster negatives were released from their human subjects, cast and placed upon their pedestals, their faces have been void of the inner elements which once made them human; they lie in a somewhat vacuous state as mere shells, imprints of faces, and yet there is something wholly unnerving about them. For contemporary viewers to gaze at the facial contours and momentary expressions of these once living subjects, an empathic, phenomenological stance, enjoining the viewer's affective experience to that of other viewers, may enable one to appreciate the horror and nausea expressed by Miss Beaton as she was drawn to the irregular 'shapes and expressions' of the wax faces in the medical museum. Their stark realism induces a reaction which is difficult to verbalise, evading representation, but which may nonetheless leave a lasting impression on those who encounter them. Since such material objects can be seen, felt, touched and experienced, it has been argued by anatomical museum specialists such as Thomas Schnalke that, because of their close proximity to the human form, such objects may induce the sensation of 'schaulust'.¹²⁰ That is, viewers may be drawn to their extreme life-like appearance, but simultaneously they may be repelled by the facial grimaces, clenched lips and furrowed brows, that are so expressive of pain and discomfort. As Miss Beaton spoke of being unwillingly drawn to their faces, to the pain and discomfort they 'dumb[ly]' expressed, we too may find ourselves empathising with such discomfort and disconcertion.

In one final letter written to Dr Henderson on the subject of the wax heads, the following excerpt demonstrated most clearly the fear, expressed by Miss Beaton, of her identity being forcefully displaced by the medical profession and by those around her. With her sister having trained in mental nursing at Gartnavel some years previous to Miss Beaton's admission, she began her letter, written on 8th February 1927:

Dr Henderson ... To think that my sister used to live, when she was here, over in the rooms that Miss Brodie is in now + that I am in a place like this - ... Though mental was her pet subject – she need not have put me, in her imagination – with your

heads were produced in plaster rather than wax, the base of these objects reveal that before these heads were repainted in the 1990s, they were originally colored in a flesh like tone, and therefore could have been mistaken for being made from a waxy medium.

¹²⁰ 'Schaulust' is defined by Schnalke as experiencing simultaneously sensations of curiosity and repulsion.

encouragement it seems – on a pedestal along with the other wax heads I told you about + placed me in the same category + left me there. The nurses hit the patients + say it does not matter because they haven't the same feelings mental or physical as other people – but perhaps, in some cases their feelings are intensified, where a person with a blunter, coarser mind would not mind such treatment. It was said that the bravest soldiers in the war were those with the dullest intellects, they had the least feelings. Please do not keep me up here any longer.¹²¹

As the intersection of anatomical realism and the medical knowledge of the Victorian era produced a set of objects that threatened Miss Beaton's sense of self and health, so the wax heads show, in the most tangible of ways, the lasting hold that the mental deficiency diagnosis held over the psychiatric profession and the public imagination in the early twentieth century. As Sander Gilman suggests, such objects taught their viewers to identify the physical, outer characteristics of mental illness betrayed by the human body, but these images could simultaneously produce an 'anxiety about identifying oneself with the image of the mad'.¹²² As such faces of 'idiocy' were internalised by Miss Beaton, and projected upon the patients who surrounded her, her fear that her own identity was being aligned to such a stigmatising and determinist diagnosis was, in many respects, a well informed and correct assumption. The diagnosis of moral deficiency wedded her identity to that of the more physically stigmatised and intellectually 'deficient' category of mental defect, and therefore her confinement in the refractory ward, alongside the most disturbed and unmanageable of patients, pressed upon her an identity that was regarded by many with moral censure. As plaster casts and wax moulages blurred the boundaries between real and artistic representations of mental illness, they too may have blurred the boundaries between object and onlooker. When Miss Beaton came to be housed amongst a class of patient who were the embodiment of insanity, it is arguable that this feeling of 'schaulust', of curiosity and repulsion, of rejection and self-recognition, seriously challenged her own ontological stability.¹²³

At one level, we may therefore comprehend why, throughout six years of confinement, Miss Beaton utilised objects, literary, theological and medical discourses that defined lunacy in terms of physical stigmata and hereditary degeneration. She argued that her head was unjustly showcased, that she did not fit the physical mould, and discourses built upon the notion of degeneracy enabled her to demarcate the perceived world of the insane from

¹²¹ Letter written by Miss Margaret Beaton on the 8th February 1927 GB812 HB13/11/2 NHSGGCA.

¹²² Sander L. Gilman *Health and Illness Images of Difference* (London: Reaction Books Ltd, 1995) p. 50.

¹²³ Schnalke *Diseases in Wax* p. 204.

her own enclosed self-space. It enabled a degree of ontological security within an environment that was subjectively experienced to undermine her sense of self and health. But at another level, we may contemplate the Foucauldian argument that, as scientific discourses seep into the cultural consciousness and as images of mental illness become embedded within a society, the 'medical gaze' becomes internalised.¹²⁴ Since Miss Beaton lived in an era when individuals were exposed to images of mental illness encouraging them to survey themselves and one another through an array of cultural and scientific lenses, I am therefore intrigued by the idea that Miss Beaton turned this medical gaze upon herself. Resisting, yet increasingly finding the hospital environment enforced a patient identity upon her, her inability to escape either the horrors of the past or the confines of the present gradually gnawed at her sense of self. Her head - her identity - was slowly becoming encased, as she experienced the imposition of a 'mad' identity.

Conclusion: Henderson revisits Miss M.B. and the figure of the psychopath

After spending a total of twelve years at Gartnavel, Miss Beaton's patient case note records came to an end, as she was transferred to another mental hospital. Her fate has so far evaded further detection, but her published case history lived on. By the late-1930s, Henderson was becoming one of the most widely renowned experts on the psychopathic states, influencing the diagnosis and treatment of such problematic patients on both sides of the Atlantic.¹²⁵ In 1939, several months after Henderson delivered the Thomas W. Salmon Memorial Lecture on the subject of the psychopathic states to the New York Academy of Medicine, his research into psychopathic personalities was published in his book *Psychopathic States*, a text that would come to characterise Anglo-American delineations of the psychopathic personality over the following decades.¹²⁶ In the introduction to his book, Henderson summarised the perplexities faced by psychiatrists: 'I have become more and more conscious of [the] bewilderingly complex nature' of the psychopathic states, a topic which he considered, had been 'so strangely neglected' that he

¹²⁴ Sharrona Pearl *About Faces, Physiognomy in Nineteenth-Century Britain* (Cambridge: Harvard University Press, 2010) p. 173.

¹²⁵ Psychiatrists today, such as Peter Tyrer, who research upon the personality disorders, continue to be stimulated by Henderson's work. Henderson's published account of personality disorder in 1962, in the Ninth Edition of the *Text-Book* inspired Tyrer to pursue research into the personality disorders, see Peter Tyrer 'Personality Disorder' p. 81.

¹²⁶ Jessica H Lee 'The Treatment of Psychopathic and Antisocial Personality Disorders: A Review' *RAMAS* (1999) 1-33 pp. 1-2.

regarded it as being ‘worthy of reformulation’.¹²⁷ Having rejected the terms moral insanity, imbecility or deficiency, and having further developed the diagnostic category of constitutional psychopathic inferiority, the case history of Miss M.B. was, by 1940, removed from the *Text-book* chapter on ‘Mental Defect’ and reinstated as the prime example from which to demonstrate the ‘complexity’ of the ‘psychopathic states’.

Plucked from a diagnostic category laden with prognostic pessimism and moral censure, Miss M.B.’s published case history underwent reformulation. Not only had the diagnostic framing been radically revised, the contents of her published case history had undergone a subtle transformation. Rather than introducing her case with a report of her disruptive behaviour, Henderson began by describing Miss Beaton as having been a ‘single ... young lady of attractive appearance and address, who came from a neurotic stock’. These purposeful additions, which emphasised the beauty and attraction of his former patient, suggest an increasingly complex, even ambiguous set of relations felt by Henderson towards Miss M.B. Moreover, his description of her ‘neurotic’ family members subtly undermined the legitimacy of her brother’s tale, whose description of Miss M.B. was the lynchpin of the *Text-Book* account. Despite these changes, however, her case history then read as before (see Appendix): word by word, the 1940 *Text-Book* summarily detailed her having drenched the hens, jeered at the morbid atmosphere of the sick room and tormented the most defenceless of patients within Gartnavel. But one final, telling addition to her case history read as follows:

She is sulky, spiteful and destructive, making life difficult for the other patients, and even striking those who are most helpless. **At other times she can be most attractive and charming, and seems almost out of place as a patient in a mental hospital** [my emphasis].¹²⁸

As it was noted that Miss Beaton seemed ‘almost out of place as a patient in a mental hospital’, this final statement reflects the changing medical, legal and social disputes that surrounded such cases. In the years leading up to the publication of *Psychopathic States*, debate over the appropriateness of placing such individuals within mental hospitals

¹²⁷ In being invited to deliver the Thomas W. Salmon Memorial Lectures to the New York Academy of Medicine, this demonstrates that reciprocal relations between Scotland and North America were established through Henderson. See the introduction and also Henderson *Psychopathic States* p. 79.

¹²⁸ Henderson and Gillespie *Text-Book of Psychiatry* (1940) p. 310.

increasingly surfaced in text books, journal articles and symposiums.¹²⁹ With Henderson arguing for the re-education and rehabilitation of psychopathic individuals within community based medical centres, rather than confining them to asylums or prisons, the argument made by Miss Beaton herself, that she did not belong among the patients of a mental hospital, was now being articulated in professional circles.¹³⁰

In the public domain, the justification of such an argument predominantly lay with the re-conceptualisation of the diagnostic category. Rather than define such individuals as a hereditarily determined class of criminal, whose antisocial behaviour stemmed from birth, psychiatrists such as Henderson were increasingly demonstrating how environmental factors shaped the development and diagnosis of such individuals. By presenting the case histories of those recognised as psychopathic individuals whom he had encountered within mental hospitals, psychiatric clinics, prisons and private practice, Henderson made the somewhat radical proposition that the antisocial disorders of the psychopath could play out, not only in aggressive, narcissistic or emotionally blunted patterns of behaviour, but also in producing individuals who were predominantly creative, possessed of genius and great sensitivity.¹³¹ Whether or not the psychopaths' 'susceptible' minds would lead to the formation of an antisocial personality, argued Henderson, could depend greatly upon the environment in which they lived. 'Broken homes, inharmonious family relationships producing jealousy and hate, unemployment, poverty and all other social ills', wrote Henderson, all aided in the production of such aggressive and inadequate personalities.¹³²

In other cases, he remarked, there were those who developed under 'excellent material conditions' and whose family relations and educational backgrounds were exemplary, but who, despite such advantages 'repeatedly ... prove a disappointment to all who have strained to help them'.¹³³ Hereditary, neurophysiological, endocrinal and biochemical factors were therefore accepted alongside environmental and psychological features of causation, but at bedrock Henderson frankly admitted that no clear aetiology could be discerned. Facing such unsettled and variable patterns of causation, Henderson nonetheless

¹²⁹ Anon 'Moral Imbecility and the Mental Deficiency Act' *The British Medical Journal* June 13 (1914) p. 1316.

¹³⁰ Petrie 'Review of Psychopathic States' p. 572.

¹³¹ Such a division of psychopathic states into aggressive, inadequate and creative subgroups was not considered by Henderson to be in any way a clear cut as such states 'merged into one another', yet such groups argued Henderson were 'sufficiently distinct to facilitate discussion and comparison'. Henderson *Psychopathic States* p. 43.

¹³² Henderson *Psychopathic States* pp. 35-36.

¹³³ *Ibid* p. 127.

noted two fundamental features which constituted the psychopathic state and which differentiated this diagnostic category from other types of mental disorder. Summarised under the headings of *Psychic Immaturity* and *The Influence of Fear*, Henderson argued that, irrespective of the particular circumstances that infused the life histories of such individuals, the psychopath was a person who, quite simply, 'fails to grow up'. The egotistical drive for independence and for the gratification of desire were seen to go unchecked as the psychopath developed neither altruistic feelings, nor did they learn from experience the disadvantages of their dissocial behaviour. In failing to take into account the feelings of others, the psychopath, argued Henderson, often found themselves in social isolation, and yet still they yearned for companionship. Driven by the instinct of self-preservation, an instinct that Henderson associated with the need for maternal love and the protection it afforded, the psychopath, wrote Henderson, was frequently denied such close and protective relationships because of their egotistical and asocial behaviour.¹³⁴ Often regarding themselves as outcasts, as being misunderstood, the psychopath, Henderson continued, lacked the 'support', 'happiness' and 'courage' fostered within social groups and close familial relations. Leading 'almost inevitably to fatalism and despair', their responses to fear were exaggerated under conditions of 'solitude and loneliness'. They felt pain and anguish more intensely, while their responses to emotional stimuli became disproportionate. The seeming irrationality of the *aggressive* psychopath, theorised Henderson, could be understood as the response of a personality dominated by fear whose spiteful, destructive and violent actions were a means of self-preservation.¹³⁵

Written from within her single room in the upper wards of Gartnavel, Miss Beaton's letters expressed - sometimes in the most vitriolic, sometimes the most plaintive of terms, such pain, despair and fear. Invoking a sense of self that was bound to distinct affective spaces; of a building which was so intimately experienced, and surroundings which were felt to be so sickening and suffocating, her narrative began to unveil this most complex of relations between identity and environment. Her letters, which were carefully filed away, were written in an institutional and social environment which enforced such isolation and

¹³⁴ Transcending the orientation of Freudian psychoanalysis to the centrality of sexuality, Henderson built upon the theories of psychiatrists such as Ian Suttie, Ernest Jones and Karl Birnbaum to suggest that love is a 'mechanism of self preservation', driven by the need, not for sexual gratification, but for food, and therefore the 'original object of love is the mother', her companionship is essential to the survival of the infant and therefore if this desire is not attained, it may 'produce intense emotional distress such as anger, rage, terror...' This desire for companionship and protection, theorised Henderson, is a lifelong desire and therefore social isolation may produce these same intense emotions later in life. Henderson *Psychopathic States* pp. 130-131.

¹³⁵ *Ibid* pp. 128-134.

solitude, and which negated the authenticity of her words. Yet it is apparent that, within such material conditions, Henderson's own comprehension and representation of her illness and identity began to converge with that of his patient. Years later, as Henderson gained the power to influence public opinion and social reform, the experiences, sentiments and stories of patients such as Miss Beaton can distinctly be heard, weaving back and forth through his publications. When Henderson wrote in the 1930s that the stories of such patients were 'often not listened to', or that, if they were, they were 'not given a great deal of credence', the value of Miss Beaton's narrative to the diagnostic process and to the development of psychiatric knowledge is most clearly acknowledged.¹³⁶ Only through the in-depth analysis of the psychopath's life history, wrote Henderson, only by listening to their stories and analysing their 'social, racial, economic and personal problems', could psychiatrists begin to understand and modify their wayward personalities.¹³⁷

Indeed, through the analysis of patient stories and case history reports, Henderson went so far as to question whether 'modern civilization, partly by its restriction, and partly by its freedom of licence and lack of understanding, [was] not manufacturing a good number of psychopaths'.¹³⁸ Such a manufacturing process, whereby society impresses distinct modes of adaptation upon its individual members, was most notably articulated by Miss Beaton within Gartnavel, where she spoke of the disciplinary regimes, practices of segregation and the enforcement of distinct medical identities within the microcosm of the hospital environment. When Henderson wrote that society made scant attempt either to understand or to accommodate such individuals, and that the tendency of the law was punish rather than to re-educate and rehabilitate the psychopathic personality, his argument once more overlapped with that of Miss Beaton, who spoke of her confinement in terms of punishment and incarceration. Indeed, Henderson rationalised the 'immoral' behaviour of such individuals, insisting that, due to the lack of understanding and recognition shown by society, it was little wonder that the aggressive psychopath often became 'bitter', coming to 'hate society and [themselves] and attempt[ing] to square accounts by whatever impulse is, for the moment, in the ascent'.¹³⁹ Removed from a society where she faced repeated rejection and disempowerment, and alienated from her family who expelled and rejected her, the acts of aggression, manipulation and petty persecution displayed within the

¹³⁶ Ibid p. 46.

¹³⁷ Ibid pp. 150.

¹³⁸ Ibid pp. 19, 44-46.

¹³⁹ Ibid pp. 19, 44-46.

confines of Gartnavel reflected her need to square such accounts, to inflict upon others the pain that she endured. Henderson wrote of the psychopathic personality being driven by an intense desire for self-preservation, and a parallel chord is struck with the sentiments expressed by Miss Beaton as she fought to resist the imposition of a mad identity.

As this chapter fluctuates between the individual perspectives of Miss Beaton, her family members and Gartnavel's medical officers, and the broader socio-historical contexts in which her case history was produced, it is arguably only through the integration of small-scale, micro-histories of space, place and the individual imagination, with large-scale, macro-histories of illness and identity that concepts such as moral imbecility, psychopathic states or antisocial personality disorder may genuinely be recast into something three-dimensional. To procure an in-depth understanding of personality disorder and its diagnostic history, the case note records of Miss Beaton demonstrate that such comprehensibility derives, not only from the analysis of the most overt and immediate contents of patient narratives and psychiatric discourses, but also from the ruptures, inconsistencies and finally to the commonalities that underlie such texts. From out of a fractured and at times openly hostile relationship, there emerged a bond between Henderson and Miss Beaton that was creative and constructive, built upon relations of empathy, respect and finally of understanding shown by Henderson towards Miss Beaton. As Miss Beaton relinquished her story to Dr Henderson, as she invited him to peer into her own phenomenological world, I strongly argue that her narrative actively informed and reshaped Henderson's interpretation of the diagnostic construct.

I therefore hope to have demonstrated that such problematic personalities cannot be regarded, as Cleckley stated, as a 'reflex machine, which mimicked emotion and faked conviction'.¹⁴⁰ Rather, as their subjective experiences of illness and identity are explored, they begin to unveil this complex relation between emotion, illness, experience and identity. Such stories, once embedded within their distinct environmental settings, demonstrate not only an accrual of knowledge as to the signs and symptoms which characterise the personality disorders, but reveal the active role played by patients, practitioners and society itself in the creation of such a diagnostic category.

¹⁴⁰Millon *Personality and Psychopathology* p. 15.

CONCLUSIONS

Taking at its heart the recorded interactions between patients and psychiatrists, this thesis has used Gartnave's case note records and corresponding archival materials to craft a 'history from below' of psychiatric practice and asylum care. Material traces of dynamic clinical encounters have been interwoven into a succession of chapters, each of which looked to 'picture, to populate and to personalise the pasts' which have been the focus of this thesis.¹ Taking heed of Erwin Ackerknecht's plea for a 'more extensive and more critical analysis of what doctors *did* in addition to what they thought and wrote'², a history emerged, not just of psychiatrists, but of patients, co-producing experiences, spaces, diagnoses and prognoses. Promising to reveal a time and place in the history of Western psychiatry that offered remarkable insights into the history of psychiatric practice and clinical encounters, I offer an original, interdisciplinary approach to records which are near unique in their elucidation of dynamic clinical encounters and of psychiatry *in the making*. Drawing to a decisive conclusion, I consider the work that this project has undertaken and future implications for academic debate.

Outlining a theoretical framework

Following a critical engagement, in chapter one, with the subject's diverse historiography, a sustained effort has been made to navigate the pitfalls and recognise the achievements of past academic works, while establishing my own theoretical approach. Distinguishing the role played by case note, and case history, records in the history of psychiatry/mental illness, I carved a case note orientated path through the subject's historiography. Stretching from the divisive era of the 1960s, to the more integrated, interdisciplinary focus of researchers in the twenty-first century, I questioned how contemporary politicised judgement steered the course of this varied, often fractured historiography. In doing so, past models of social control, as established by Goffman and Foucault, were confronted, enabling me to take seriously how hospital buildings, psychiatric practices and record

¹ Hayden Lorimer 'Caught in the Nick of Time: Archives and Fieldwork' in *The SAGE Handbook of Qualitative Geography* eds. Dydia DeLyser, Steve Herbert, Stuart Aitken et al (London: SAGE Publications, 2009) p. 257.

² Erwin Ackerknecht 'A Plea for a "Behaviorist" Approach in Writing the history of Medicine *Journal of the History of Medicine and Allied Sciences* 22 (1967) 211-14.

keeping devices should be noted for their regulatory function as well as their empowering potential. The politicised judgements of past Marxist, anti-psychiatry and feminist scholars motivated me to pursue my own revisionist history of patient-psychiatrist relations, and while considering subsequent criticisms of these works, I reflected on the potential downfalls risked by a-historical theorising. Seeing value in the diverse methodologies promoted by social, cultural, anthropological, literary, psychoanalytic and traditional medical histories, towards studies of psychiatry, mental illness and clinical practices, I embraced an interdisciplinary approach, through which to do justice to the holistic nature of Henderson's dynamic psychiatry.

Scales of analysis and the paradoxes of a science of the individual

Running throughout my research has been the recognition of the paradox, conceptualised in different registers by Michel Foucault and Ruth Leys, that underlies the theories and practices of psychiatry; namely, this notion of a science of the individual.³ Dynamic case note records fluctuated between constructions of a life history, emphasising individuality and the unique socio-environmental conditions underlying a case, and the typological categorisation of patients by patterns of reaction and adaptation. My work too fluctuated between, on the one hand, the examination of the personal and particular and, on the other, the larger frameworks of analysis that embed the history of Henderson, Gartnavel and its patient population. Conscious of the pronouncement, made by Andrew Scull, that micro-histories of patients, practitioners and individual institutions run the risk of merely recording 'incremental change that retreat into a sort of neo-solipsism', my own detailed empirical analysis, while illuminating the inner, day-to-day activities of mental hospitals, is placed in a macro framework of analysis, one looking outwards to the wider social, economic, theological, moral and political contexts in which such encounters took place.⁴ It is this wide, and fluctuating, framework of analysis that was fully realised in chapter seven, as the individual case of Miss Beaton was used to address both the historical origins, and contemporary legacies, which surround notions of morality, social control and the role of the psychiatric profession in defining and confining those considered mentally ill. Wrangling with the ontological status of mental illness, this approach, while not denying the 'objective reality of certain signs and symptoms or their underlying psychobiological disorders', debates the extent to which diagnostic categories are products

³ Foucault *Discipline and Punish* pp. 185-191. Leys 'Types of One: Adolf Meyer's Life Chart and the Representation of Individuality'.

⁴ Scull *The Insanity of Place/ The Place of Insanity* pp. 108-08.

of moral, political and other culturally mediated judgements.⁵ Indeed, in the case of Miss Beaton, the mediatory process between patient and psychiatrist is shown to be quite profound, as Henderson's redefinition of moral deficiency was, in many ways, to uphold Miss Beaton's own rejection of the diagnostic category and its attendant patient identity.

Narrative frameworks, enabling interdisciplinary perspectives

Looking back to the introduction to this thesis and my overview of Oliver Sacks, I argue that an adherence to a discourse form, one intertwining nomothetic forms of exposition with idiographic methods of investigation and understanding, enabled my research to traverse diverse geographical, spatial, temporal and individual histories from an array of disciplinary approaches. In this thesis biography, storytelling and narrative techniques, as used by Sacks and Arthur Kleinman, were used to unite the multiple threads of clinical tales, so as to provide a more nuanced, less one-sided history of the interactions between patients, psychiatrists and family members. Beginning with a biographical account of Henderson's early years of training, a narrative approach enabled my work to pull together the wider medical, cultural and geographical contexts in which his own life was set, conjoined with a more intimate account of his personal history. In chapters six and seven, storytelling was again used to embed patient correspondence within the social, spatial and temporal contexts in which it was produced, so as to begin to understand how patients choose to express their inner psychological states.

As well as using correspondence records to generate a set of stories through which to give expression to this period in history, I analysed the ways in which psychiatrists, patients and informants were themselves using narrative techniques and rhetorical devices when constructing the case note record. Chapters three and four discussed Gartnavel's case note records from two distinct, yet intertwined perspectives, enabling the study of patient cases as both the formation of the 'type' and the 'individual'. On one hand, I looked to the narrative structures and record-keeping devices practised in accordance with dynamic examination guides, which regulated and homogenised patient case note records. On the other, I showed how the case note record functioned to capture the unique stories/illness narratives constructed by patients, informants and psychiatrists, taking into account how clinical environments, cultural contexts and the vagaries of mental illnesses shaped the

⁵ Wallace 'Historiography, Philosophy and Methodology of History' p. 59. See also Rosenberg 'Introduction Framing Disease: Illness, Society, and History'.

contents and delivery of these narratives. These differing scales of analysis were next applied to chapter five when discussing the formation of diagnoses, prognoses and plans for treatment within the staff meeting. In particular the subsection entitled ‘archaeology of silence’ was used to evidence the stories of patients who were silenced, disempowered and/or alienated from society, because of illness and institutional confinement. Archival shards, denoting patients’ presence upon Gartnavel’s wards and examination rooms, were interwoven within larger, more fully documented histories, thereby evidencing their significance to the historical record alongside more voluble and/or literary patients.

Moving on to chapter seven and the multiple stories, biographies, literary tropes and medical narratives encased within a complete case note record, I recognised, in alignment with Mikkel Borch-Jacobsen, the unsatisfactory nature of studies that alone describe the ‘theories and practices of ... psychiatrists, or, inversely, the subjective experience of ... patients’.⁶ Therefore while highlighting these often-polarised perspectives, a narrative account allowed me to intertwine, to dramatise, and to extrapolate from these interactions, a history of the new, shared realities, that emerged from clinical encounters. Divisions between *nomothetic* studies, of ‘disorders, mechanisms and syndromes’, and *idiographic* descriptions, of personal experience and empathic understanding, were conceived as limiting constructions of complex, multi-authorial and differentially experienced histories of psychiatry/mental illness.⁷ Taking as the central point of study, those complex clinical encounters ‘that give rise ... to new psychiatric concepts and symptomatic behaviours’, I paid attention to the agency of both patients and psychiatrists in defining and promulgating notions of illness and identity.⁸

While a narrative framework facilitated an interdisciplinary approach, storytelling was also used to promote an empathic response to the lives of historical actors. Parelleling psychiatrists such as R. D. Laing, Miriam Siegler and Theodore Millon, and academics such as Allan Ingram and Charles Rosenberg, I recognised the study of mental illness to be the study of inner cognitive, corporeal mechanisms and processes in complex relation to the environments in which one’s sense of self takes form. To grapple with an interlocking system of memories, unconscious mechanisms and cognitive processes which, over time, shape how individuals perceive, relate to, think about and ‘cope with the environment and

⁶ Borch-Jacobsen *Making Minds and Madness* p. 9.

⁷ Sacks *Awakenings* pp. xxxvi-vii.

⁸ Borch-Jacobsen *Making Minds and Madness* pp. 8-9.

oneself', demands a thorough engagement with the life histories, the illness narratives, the tangible settings and social contexts in which individual lives took shape.⁹ When endeavouring to build an affective connection to the physical sites and personal histories that populate this thesis, I concede that I stand dangerously close to 'recapturing, rather than recovering' the phenomenological worlds of the individual patients and psychiatrists under study.¹⁰ By becoming 'embroiled in the site' of research, it may be argued that I run the risk of losing academic objectivity, and of imposing my own interpretive narrative upon the material traces of historical actors.¹¹ Being guided by the affects induced by individual stories, or by objects, such as the Hillings masks, which I myself felt, touched, photographed and experienced, the boundaries, which distinguish the observing and impartial scholar from the participant researcher, inevitably blur. But I consider it is precisely because of my own, and other researcher's ability to create empathic, affect-based relations with historical actors that we may truly begin to understand the objects of our research. For, as psychiatrists such as Femi Oyeboode state, the practice of psychiatry must not only observe and 'explain natural phenomena by causal explanation', but also seek to 'understand human psychiatric phenomena' on an empathic level.¹² 'It is the imagination of other people's worlds', writes Sacks, 'worlds almost inconceivably strange, yet inhabited by people just like ourselves, people, indeed, who might *be* ourselves' that he claims as the real strength of his research, foregrounding wider social, as well as psychiatric exchanges with mental health sufferers.¹³ By engaging directly with the dialogues that passed between patient and medical officers within clinical encounters, this thesis has offered an historically informed story of medical humanism – of doctor-patient relationships – that are at the very heart of the history of psychiatry/mental illness.

Political usage of history, and to conclude with my own engagement with contemporary scholarship

Histories of psychiatry/mental illness have long been politically charged, interacting and at times shaping the face of contemporary political policy, popular opinion and psychiatric practice. In the 1960s, when Henderson published a history of dynamic psychiatry in *The*

⁹ Millon *Personality and Psychopathology* p. 15.

¹⁰ Porter *The Faber Book of Madness*. For remarks on its public reception see Andrews 'Grand Master of Bedlam: Roy Porter and the History of Psychiatry' p. 270.

¹¹ Dewsbury 'Performative, Non-Representational, and Affect-Based Research' p. 326.

¹² Oyeboode *Sims' Symptoms in the Mind* pp. 15-16.

¹³ Sacks *Awakenings* p. xxxviii. I go somewhat beyond this logic, as the desire to generate empathy and understanding was extended to the lives of Gartnavel's psychiatrists, Henderson in particular, whose world steadily gained substance through snatches of correspondence, biography and case note records.

Evolution, this text was used precisely to attack the reductivist leanings of biomedical psychiatry. ‘Not long ago’, wrote Henderson:

[W]hen I told a young psychiatrist that we had been successful in helping many patients to recover before modern physical methods of treatment had been introduced (1934) he appeared incredulous and said that he had been taught that previous to 1934 the prospect of mental patients recovering without the use of electro-shock therapy was practically nil. His attitude made me wonder whether the art and practice of psychiatry were becoming too mechanically minded, and whether we were losing something of the human element which means so much.¹⁴

In 1977, George L. Engel, professor of psychiatry at the University of Rochester, New York, voiced renewed interest in ‘neo-Meyerian’ psychiatry, then labelled in North America as the ‘biopsychosocial’ model. To destabilise the ‘dogmatism of biomedicine’ and to re-establish psychiatry as pre-eminently a ‘human science’ was the driving force of his paper. ‘How can a proper balance be established’, he asked in alignment with Sacks, ‘between the fractional-analytic and the natural history approaches, both so integral for the work of the physician?’ ‘How’, asked Engel, in the words of Margaret Mead:

Can the clinician be helped to understand the extent to which his scientific approach to patients represents a distinctly “human science”, one in which “reliance is on the integrative powers of the observer of a complex nonreplicable event and on the experiments that are provided by history and by animals living in particular ecological settings ... ?

For Engel a good starting point was to look back to the history of the ‘rise and fall of scientific dogmas’. By unearthing the ‘power of vested interests’ that uphold biomedical dogmatism, Engel saw scholars as having the ability to critique its present day hold on psychiatric practice. By revealing the shortcomings of a biomedical model, Engel called for a biopsychosocial model that takes into account ‘psychological, social, and cultural [meanings] as well as ... anatomical, physiological, or biochemical’ determinants of mental illness.¹⁵

Today members of the psychiatric profession likewise use histories of dynamic psychiatry to political effect. Calling for psychiatry once again to embrace the holistic approach of

¹⁴ Henderson *The Evolution* p. 223.

¹⁵ George L. Engel ‘The Need for a New Medical Model: A Challenge for Biomedicine’ *Science* 196 (1977) 129-136 p. 135.

dynamic psychiatrists such as Meyer and Henderson, the biopsychosocial method is offered as a counterweight to the reductivist orientation of biomedical psychiatry. '[I]f American psychiatrists abandon their humanistic and psychological or biopsychosocial approach; for a purely molecular biological and pharmaceutical one', writes Edwin R. Wallace:

[T]hey will indeed be repeating what their late nineteenth and early twentieth century counterparts had done. Seized by a comparable desire to medicalize, those turn-of-the-twentieth century doctors relinquished the psychosocial insights and practices of the previous generation, thereby sacrificing psychiatry's unique contribution to general medicine.¹⁶

Moreover, scholars such as David Pilgrim argue that the biopsychosocial model offers 'professional advantages for psychiatry and humanistic benefits to mental health service users'. In the face of renewed criticism, from the 'mental health service users' and 'critical psychiatry,' against the biomedical orientation of Anglo-American psychiatry,¹⁷ scholars such as D. B. Double highlight the importance of Meyer and his influence upon contemporary biopsychosocial models. Arguing that Meyerian psychiatry should once again be given widespread recognition, he advocates:

A consensus for the biopsychosocial paradigm ... be re-established by a challenge to biomedicine that is positive, as was Meyer, about the inherent uncertainty of medicine and psychiatry.¹⁸

Critics of DSM-V, representing the view of the British Psychological Society (BPS), are likewise calling for the recognition of uncertainty, and the greater inclusion of 'psychosocial factors such as poverty, unemployment and trauma' in diagnostic manuals. Mental distress, they state, should be thought of 'on a spectrum with 'normal experience', rather than bracketed off into distinct categories of abnormality. Envisaged to 'stem from ... frameworks of understanding the world, frameworks which are themselves the product of the experiences and learning through our lives', these sentiments harmonise with those

¹⁶ Wallace 'Historiography, Philosophy and Methodology of History' p. 63. Meyer and Henderson are, of course, exempt from being labeled as psychiatrists who, at the turn of the century, turned to a materialist biomedical model. They were indeed the counterweight to the Kraepelinian symptomatological classificatory system and to the increasing dominance of the biomedical model in decades to come.

¹⁷ Pilgrim 'The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future?' p. 593.

¹⁸ Double 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine' p. 337.

of Meyer and Henderson:¹⁹ '[O]ne cannot think of mental cases in groups', wrote Henderson in 1921 'but each case has to be considered as an individual problem, caused and brought about by real definite difficulties in that individual's life'.²⁰ In the following recommendations made by the BPS, their call, for diagnostic systems to afford greater recognition to the individuality of each case, chimes a chord with such principles. Moreover, benefits arising from the production of case histories ('case formulations'), as vehicles for communicating the particulars of a case to 'staff and clients' are rigorously affirmed:

Rather than applying preordained diagnostic categories to clinical populations, we believe that any classification system should begin from the bottom up – starting with specific experiences, problems or 'symptoms' or 'complaints'... Since - for example – two people with a diagnosis of 'schizophrenia' or 'personality disorder' may possess no two symptoms in common, it is difficult to see what communicative benefit is served by using these diagnoses. We believe that a description of a person's real problems would suffice... There is ample evidence from psychological therapies that case formulations (whether from a single theoretical perspective or more integrative) are entirely possible to communicate to staff or clients.²¹

When engaging with contemporary debate in the emergent discipline of the critical medical humanities, the revisionist stance taken by scholars to what is arguably the rigid, hermetically sealed, diagnostic categories established in successive issues of DSM, is provoking scholars to write of the 'potential ethical benefits of remaining ambivalent' towards the 'achievements and problems of psychiatric diagnosis'.²² In lieu of current debates, where the 'act of psychiatric diagnosis' is considered as being 'embedded in complex – and very particular, social, legal, clinical, cultural, familial and psychological configurations',²³ Gartnavel's dynamic case note records may be shown to reveal, with remarkable scrupulousness, the processes by which diagnoses *cannot but be* inextricably linked to the 'complex' and 'very particular ... configurations' of the world in which they are (or were) set. Quoting Meyer, I argue that the psychobiologically (the antecedent of the dynamic model) informed case note record enables scholars to understand mental illness

¹⁹ [<http://www.nhs.uk/news/2013/08august/Pages/controversy-mental-health-diagnosis-and-treatment-dsm5.aspx> accessed 29th April 2014].

²⁰ Henderson 'Report of the Physician Superintendent for the Year 1921' p. 19.

²¹ Peter Kinderman et al 'Response to the American Psychiatric Association: DSM-5 Development' by The British Psychological Society June (2011) 1-26 [www.tinyurl.com/67wyqp7 accessed 26th June 2014] pp. 2-3.

²² Callard 'Psychiatric Diagnosis: the Indispensability of Ambivalence' p. 1.

²³ Callard 'Psychiatric Diagnosis: the Indispensability of Ambivalence' p. 5.

(and its history) as that which is created through ‘reciprocity and collaboration between physician and patient, and the relation of physician and patient together, in the midst of a human world and of human problems’.²⁴

While this thesis furnishes the historical record with further evidence of dynamic psychiatry’s role in the development of twentieth-century psychiatry, I am not, myself, in a position to advocate for its re-instigation in mainstream psychiatric practice. ‘The historian’s task’, writes Osewi Temkin, ‘is to tell what was and what has been and what has led to present conditions. As historian he or she is neither a prophet nor an ethicist, nor, generally speaking, a preacher of what should be done’.²⁵ Nonetheless, when looking to the methodological approach taken in this thesis, in many ways made possible by the contents of the dynamic case note record, I find myself in a position to state the advantages of an interdisciplinary model for contemporary scholars whose work intersects upon the study of psychiatry, mental illness and institutional care. Emulating, in so many ways, the methodology of Meyer and Henderson’s dynamic psychiatry, which intertwines nomothetic and idiographic forms of knowledge production, I, alongside scholars such as Sacks, Scull and Borch-Jacobsen, argue for contemporary scholarship further to embrace an interdisciplinary approach. To quote Felicity Callard, one of the principal aims of this project has been to ‘refocus attention on diagnosis as a complex, highly mediated process (in contrast with the preoccupation with diagnosis as classification)’.²⁶ The dynamic case note record, which Meyer envisaged as being an unbiased, clarifying account of the mental examination, has, I argue, preserved such complex, and mediated processes.

Looking back to Borch-Jacobsen’s question as to what the ‘object’ of the history of psychiatry/mental illness may be, I concluded it is not ‘madness/mental illness’, but the relations between patients, psychiatrists and the wider world, which constitute the subject of investigation.²⁷ These relations – established through dialogue between patients and psychiatrists – were precisely what Henderson and Meyer endeavoured to capture upon the pages of the case note record and the staff meeting transcript. The preservation of these dialogues is therefore precisely what makes Gartnavel’s dynamic case note records so

²⁴ Adolf Meyer ‘Talk Given at the Dedication of the Adolf Meyer Ward at the Duke University Hospital on November 29, 1940’ *The Collected Papers of Adolf Meyer, Volume III, Medical Teaching* p. 468.

²⁵ Osewi Temkin “*On Second Thought*” and *Other Essays in the History of Medicine and Science* (Baltimore: The Johns Hopkins University Press, 2002) p. 15.

²⁶ Callard ‘Psychiatric Diagnosis: the Indispensability of Ambivalence’ p. 1.

²⁷ Borch-Jacobsen *Making Minds and Madness* pp. 1-5.

significant to the history of Scottish and Western Psychiatry. These sources, which combined nomothetic with idiographic models of knowledge production, evidence a history of psychiatry in the making, that is rich and meaningful through its very complexity and ambiguity. Quoting Henderson, they enable the realisation that:

Mental illness is an individual affair. Its symptoms have little meaning apart from the setting in which they occur. This setting includes not only the general mental and physical condition at the time, but the individual's personality, circumstances and history from his earliest days. Hence general descriptions of clinical syndromes, while interesting, are not of the first importance. What is wanted always is an understanding of the patient as a human being, and of the problems which he is meeting in a morbid way with his "symptoms".²⁸

²⁸ Henderson and Gillespie 'Preface to the First Edition' in *A Text-Book of Psychiatry* (1932) p. viii.

Appendix

PSYCHOPATHIC STATES

We include under this description persons who have been from childhood or early youth habitually abnormal in their emotional reactions, but who do not reach, except episodically, a degree of abnormality amounting to certifiable insanity; they show no intellectual defect and therefore cannot be classified in terms of the Mental Deficiency Act; and they do not benefit from prison treatment. They constitute a rebellious, individualistic group who fail to conform to their social milieu, and whose emotional instability is largely determined by a state of psychological immaturity which prevents them from adapting to reality and profiting from experience. They lack judgement, foresight and ordinary prudence. "The judicial, deciding, selecting processes described as intelligence, and the energising, emotivating, driving powers called character" do not work in harmony ... The complexity of this group is best illustrated by the following case:

...

CASE 35. M.B., 24 years old, single, was a young lady of attractive appearance and address, who came from a neurotic stock. It was stated "Her vindictiveness is so extreme that she is capable of anything, while, at the same time, she is so plausible and cunning that she is able to impress all strangers that she is a persecuted saint condemned to live in a family of criminals and savages". A few instances of her conduct are sufficient to describe the case. One of her brothers arrived home on leave from France to visit his father who was dying. She refused to sit by her father when he was ill, to prepare food for him, or to relieve those who had been constantly with him night and day. On the contrary, she jeered at the constant "morbid atmosphere" of the sickroom. The family tried to induce their mother to have a nurse in the house, but she refused to do this lest a stranger should talk outside about her daughter's conduct. She terrorised the home for years, and drove more than one of her sisters away from home by her threats and her violence. On another occasion when her brother came from France, she did not speak to him during the whole time he was in

the house. She sat at meals with her face turned away from him, and when he left to return to the front he had to search her out to say good-bye, and his farewell did not meet with any response. Her mother had to sleep at night with her bedroom door locked for fear her daughter's violence, and she had also to lock her door by day in order to guard against thefts. The patient for weeks on end would not speak to any member of the family, except to demand money or clothing. It was also stated that one of her brothers, who was an apprentice engineer, had to stand over the water which he had heated to have his wash, because if he relaxed his vigilance the patient would take the warm water and pour it down the sink. One day in mid-winter she threw a bucket of cold water and deluged his hens, which were his hobby, "just to see what he would do". Frequently she told her mother that she "would make her suffer". On one occasion she walked through the house and crumbled every gas mantle into dust. She lit all the gas jets of the gas stove, and put over them every pot, pan and kettle the stove would hold, and then slipped quietly out of the house. Her habit was to rise any time from 11.30 to 2pm to cook a meal for herself, and then to leave the house without a word to any one. "What she does, where she goes, and who her friends are, none of us are quite sure." Indian ornaments, sent home by a sister, disappeared, and some Greek metal-ware which was also in the house disappeared and was discovered hidden in the commode in the patient's bedroom, awaiting a chance to be smuggled out of the house. A brother came home unexpectedly, and found his sister arguing with a rag-woman for the sale of his boots – his second pair.

On account of the difficulties of management, she was certified as being of unsound mind, and was admitted to hospital. During her stay in hospital she has been unreliable in every way. There have been times when she has been better controlled and better behaved, but sooner or later she gets into difficulty again. When found fault with, or criticised, or restrained in any way, she has outbursts of great passion, during which it is almost impossible to control her. She is sulky, spiteful and destructive, making life difficult for the other patients, and even striking those who are most helpless. At other times she can be most attractive and charming, and seems almost out of place as a patient in a mental hospital.¹

¹ Henderson and Gillespie *Text-Book of Psychiatry* (1940) pp. 308-310.

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