

HoPSIG *News and Notes*

The newsletter of the Royal College of Psychiatrists' History of Psychiatry Special Interest Group



Issue 5, Autumn 2017

HoPSIG & Archives News

Editorial

Welcome to all our readers, old and new!

HoPSIG had a full house at our spring workshop and our session at the International Congress 2017 was also well attended (abstracts are available on our [Meetings page](#)). We intend to continue holding history workshop events three times a year, including at least one meeting outside London, and we are in discussion with the Centre for the History of the Emotions at Queen Mary University of London about making links with academic historians.

This is our first issue published exclusively as an e-newsletter, the College's preferred format for this sort of publication, and we are very grateful to Mark Turner, Digital Content Officer, for setting it up and putting this issue together.

We are proud to say that HoPSIG has grown substantially, from a mere 120 people on our mailing list 2 years ago to the current figure of 1000. We are also appealing to trainees, and have three currently on the committee who are all involved in specific projects. As well as accruing interest within our own profession, HoPSIG has also had the pleasure of answering queries about the history of psychiatry from other fields and industries, including historians, radio and television producers, and a novelist. It is fair to say that we have also had a lot of fun, and we hope that you enjoy reading this issue as much as we have enjoyed reading all of your contributions and editing it!

Paul Lomax is stepping down from the HoPSIG committee, so we have a **vacancy** for another **trainee**. Most trainees join us for a year and undertake a specific project such as running a competition, helping to organise a workshop, co-editing the newsletter etc. Please [email Claire](#) if you are interested in joining us. We are grateful to Paul for establishing links between HoPSIG and the St George's medical school students-selected component (SSC) on the history of psychiatry. Several students undertaking the SSC have given well-researched talks at our spring workshops on the subjects of their dissertations.

We welcome your submissions and ideas for *News and Notes*, as well as your involvement with HoPSIG more generally. Please email claire.hilton6@gmail.com with contributions for the newsletter, or suggestions for future activities.

Looking forward to hearing from you!
Lydia Thurston, Claire Hilton
News and Notes Editors.

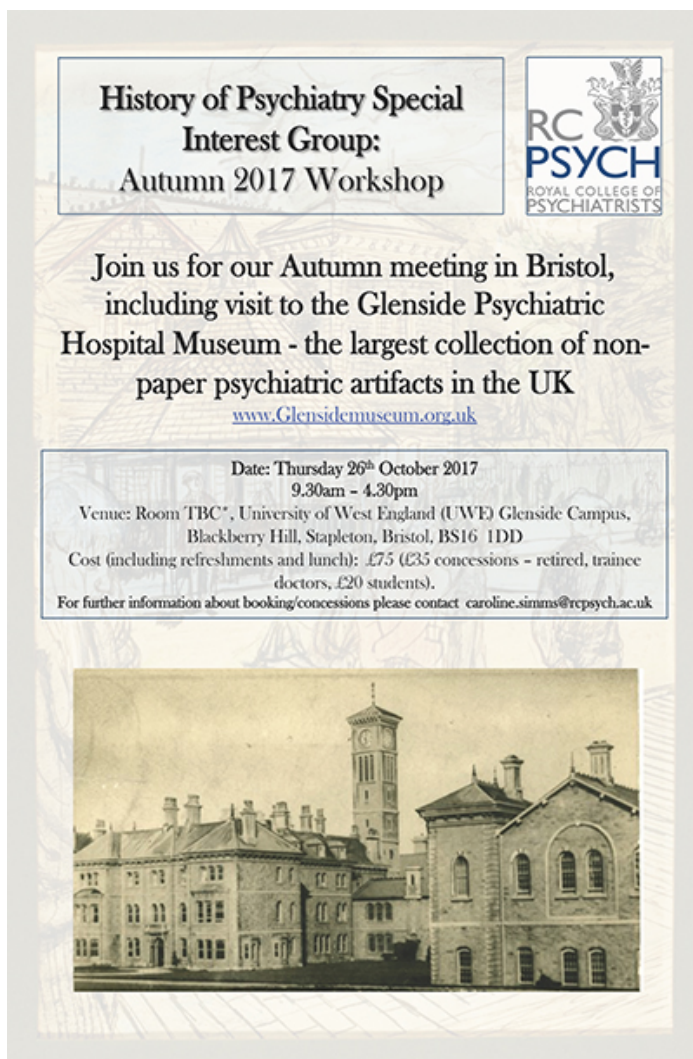
Date for your diary

Wednesday 14 March 2018
Afternoon history workshop at RCPsych
More information soon!

Events and activities

Our next event is a full day workshop at the **Glenside Psychiatric Hospital Museum, Bristol, Thursday 26 October 2017**, and we still have a few places remaining.

- [More information](#)




**History of Psychiatry Special Interest Group:
Autumn 2017 Workshop**

**RC
PSYCH**
ROYAL COLLEGE OF
PSYCHIATRISTS

Join us for our Autumn meeting in Bristol, including visit to the **Glenside Psychiatric Hospital Museum** - the largest collection of non-paper psychiatric artifacts in the UK
www.Glensidemuseum.org.uk

Date: Thursday 26th October 2017
9.30am - 4.30pm
Venue: Room TBC*, University of West England (UWE) Glenside Campus, Blackberry Hill, Stapleton, Bristol, BS16 1DD
Cost (including refreshments and lunch): £75 (£35 concessions - retired, trainee doctors, £20 students).
For further information about booking/concessions please contact caroline.simms@rcpsych.ac.uk



Write your memoir competition!

Following our last successful essay competition (which included Darren Bell's entry, published in this issue) we are having another competition. This time we invite you to **write a memoir** in 1000-1500 words about your career. The article could focus on one event/occurrence in particular or it could reflect a longer period of time. As always, we appreciate any photographs or pictures if you have any which link to your article. With your agreement, all entries will be deposited in the RCPsych archives, and the best will receive a prize and be published in *News and Notes*.

- [More information](#)

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

**History of Psychiatry
Special Interest Group
(HoPSIG)**

Competition!

**"My memoir of working as
a psychiatrist "**

Everyone has a story in them!

TO ENTER the competition:

- * write your own memoir in 1000-1500 words
- * you may include a favourite workplace photo
- * email entries by 31 Jan '18 to francis.maunze@rcpsych.ac.uk

ENTRIES will be judged by 2 HoPSIG Committee members. Criteria includes:

- * originality
- * quality of writing
- * historical interest

PRIZE!

- * £100 voucher of the winner's choice
- * the winning memoir will be published in the HoPSIG Newsletter
- * with authors' permission all entries will be stored in the College archives

Younger members could write about their early experiences of working as a psychiatrist

Archives Update from Francis Maunze, Archivist



The College Archives recently launched its [online archives catalogue](#). The creation of the catalogue is an ongoing exercise. The archivist, Francis Maunze, is now involved in adding digitised records like newsletters and published College Reports to the catalogue. This will enable members and the public to access these records without having to visit the College Archives.

The archivist is also appealing to members to inform him of any errors they come across whilst searching the online catalogue. Please [contact him via email](#).

The revised **College Archives Collections Development Policy** allows us to collect personal papers from members and fellows of the College. The archivist is therefore, appealing to **YOU** to donate those papers **YOU** think would complement and supplement the institutional records we hold.

HoPSIG Picture Quiz 4

Behind iron railings



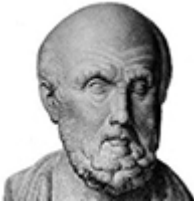
Which mental hospital, associated with Siegfried Sassoon and Wilfred Owen, stood behind these railings?

Answers to claire.hilton6@gmail.com by 30 November 2017

Answers to Picture Quiz 3

Who are these men? When did they live?

Some snippets about what they said about mental health and illness...



Hippocrates c.460-c.370 BC

First to use the term hysteria, caused by the movement of the uterus ('hysteron'). Attributed mental functioning to the brain, and attempted to classify mental disorders, including paranoia, epilepsy, mania and melancholia.



Aristotle 384-322 BC

'No great mind has ever existed without a touch of madness.' Attributed to Aristotle.



Galen, c.129- c.216 AD

Advised on keeping the six 'non-naturals' in balance and good order, to keep healthy:

- air/breathing
- exercise
- sleep
- food and drink
- excretion
- passions and emotions

Women in Psychiatry: Healers of Mind – Raka Maitra

Forthcoming exhibition and request for information

*'This you must know; the world is mine, as yours,
The pulsing strength and passion and heart of it;
The work I set my hand to, women's work,
Because I set my hand to it.'*

Excerpt from a poem by Florence Brooks Whitehouse (1869–1945), an American suffragist, recited to the judiciary committee of the Maine Legislature in 1917. ¹

The legacy of women in psychiatry is the legacy of women who established their right to education, their right to be acknowledged as physicians and their right to be recognized for their intellectual tenacity, their dedication and their compassion to better the lives of patients tormented by the vagaries of their mental health.

Our legacy includes: Dr Eleanora Fleury, the first female member of the Medico-Psychological Association, arrested for supporting anti-treaty prisoners in Ireland; Dr Doris Odlum, one of the first members of a British Medical Association group advocating provision of mental health services in the National Health Service (NHS); Dame Fiona Caldicott, who has changed the face of data sharing and security in the NHS, establishing the Caldicott principles; and Professor Eve Johnstone CBE, a pioneer of neuroimaging research in psychosis and a leading psychiatrist in recent decades. The legacy of inspiring women in psychiatry continues, with many contemporary women psychiatrists carving out new roads in treatment and research in mental health.

The Royal College of Psychiatrists is currently led by two women: the President and Dean, Wendy Burn and Kate Lovett. Historic and present day women psychiatrists act as inspirational role models to remind us that with certainty of purpose and determination we can achieve the best for our patients and write our own history in the process. The Women and Mental Health Special Interest Group, the History of Psychiatry Special Interest Group and the College Archives have therefore committed themselves to creating a virtual exhibition of women in psychiatry, aiming to launch it at the RCPsych International Congress in 2018.



© Sarah Jane Lawton

As part of the exhibition, we will also hold a workshop with the artist, Sarah Lawton, to engage women psychiatrists in exploring their identities by connecting with the legacy of historical and contemporary women in psychiatry. Lawton's printmaking workshop intends to confront one person with another, connecting individuals through woodblock, indigo, paper and cloth.

Alongside the workshop there will be a small exhibition of Lawton's work that explores co-existence, change, impermanence, unity, vulnerability, collaboration and process, captured in transient moments of shared experience. By inviting observers to become participants in an immersive experience, the artist hopes to understand and develop a 'language of gestures' through a continually changing and ever-growing print. It is hoped the virtual exhibition will stand as a testimony to women psychiatrists while the workshop will be a tangible manifestation of such a legacy being handed down to young women psychiatrists.

We hope you will join us in this celebration of Women in Psychiatry. Please feel free to [contact me](#) with your ideas, suggestions and helpful resources enabling us to realise this effort to demonstrate our legacy.

Reference

1. Alexa Tsoulis-Reay <https://www.thecut.com/2016/11/granddaughters-of-the-revolution.html>

Biographical note



[Dr Raka Maitra](#) is the secretary of Women and Mental Health SIG and, when not dreaming about the exhibition or running after her delightful little boy, she divides her time between her research work at the Cognition, Schizophrenia and Imaging lab at the IoPPN, and clinical work at Snowfields Adolescent Unit, Maudsley Hospital. She hopes to pursue higher training in child and adolescent psychiatry.



[Sarah Jane Lawton](#) is an artist and Associate Lecturer at Manchester Metropolitan University teaching MA Design & Art Direction. She holds a distinction in MA Textiles and has had solo exhibitions publicly-funded through Arts Council England and INTACH. She established the enterprise 'SHARING the MAKING' to benefit creative relationships

between UK artists and Peruvian artisans which has now grown to include Cypriot and Indian artisan groups. She has been independently developing physical and pedagogical print tool-kits and conducting printmaking workshops that focus on an immersive experience of 'interaction' and connect participants through narratives and play.

The Shaking Palsy: two hundred years on – **Richard Mindham**

"Involuntary tremulous motion, with lessened muscular power, in parts not in action and even when supported; with a propensity to bend the trunk forwards, and to pass from a walking to a running pace; the senses and intellects being uninjured."

James Parkinson, 1817.¹

The synopsis of James Parkinson's *An Essay on The Shaking Palsy* [Fig. 1.] painted a vivid picture of the syndrome which was later to bear his name. In his essay the description of the clinical features of the syndrome was remarkable for its detail and accuracy. He speculated on causes but was cautious in his opinions. He believed that the syndrome was likely to be caused by lesions in the *medulla spinalis*, possibly extending to the *medulla oblongata* in more advanced cases where speech and mastication were affected. Parkinson was familiar with earlier writings on conditions presenting with shaking, weakness and walking difficulties which had often been regarded as separate conditions. In the essay he stressed the slow progression of the disease and the importance of studying its development over a period of years. His suggestions for treatment reflected the medical practice of the day, including, leeches, purging and bleeding, but none proved to be effective.

Since his original description, the concept of the 'shaking palsy' has been modified in many respects. The syndrome was extended to include rigidity and akinesia by the French neurologist Jean-Martin Charcot and it was Charcot who, in his text book of 1877, referred to the condition as Parkinson's disease. Charcot recommended anti-cholinergic drugs for the treatment of parkinsonism which still have a limited role today.

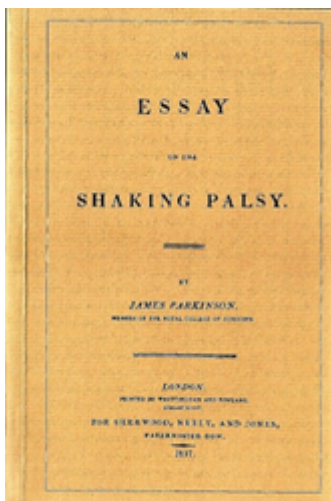


Fig. 1. Frontispiece, *An Essay on the Shaking Palsy*

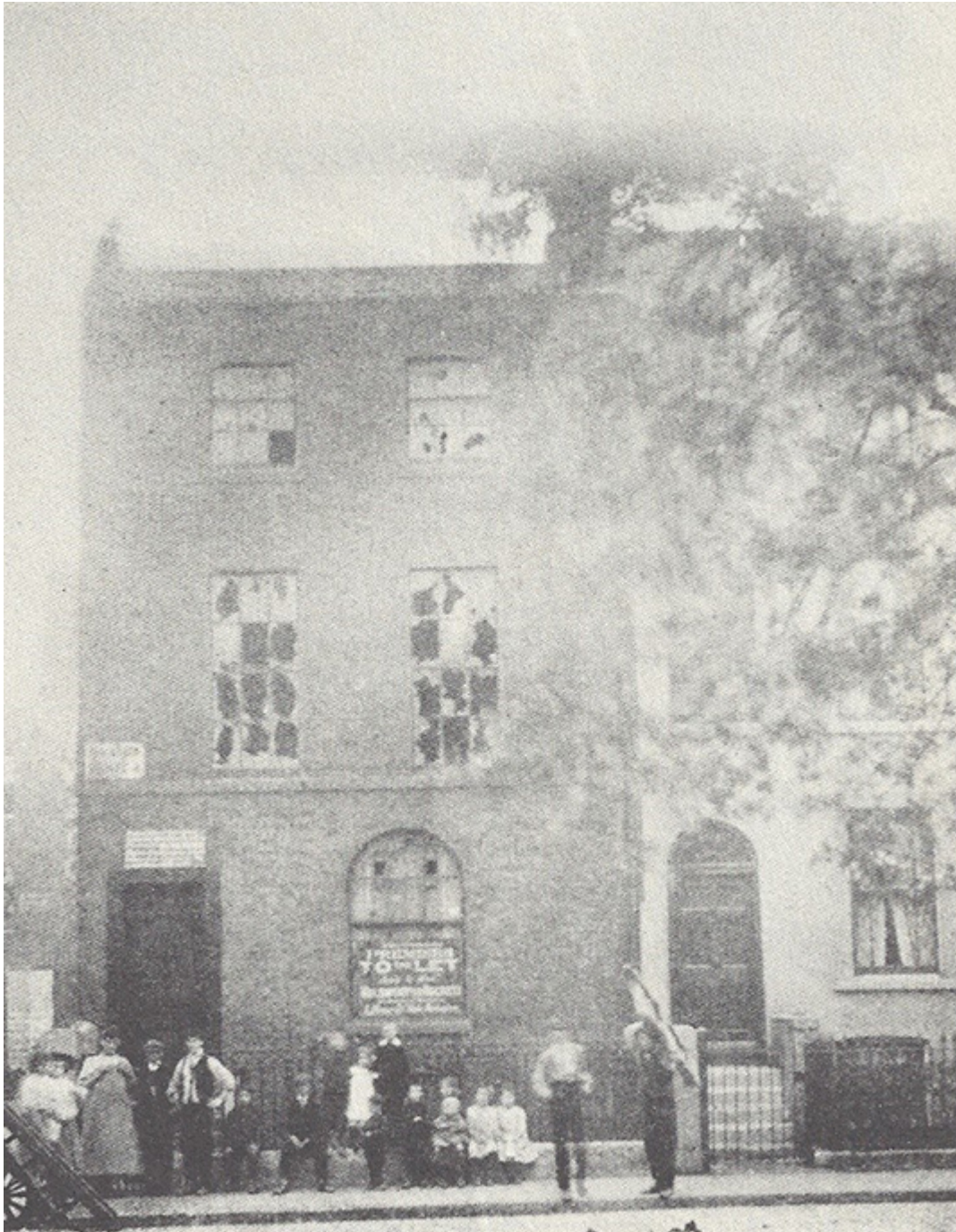


Fig. 2. 1, Hoxton Square, Shoreditch, 1912

Parkinson followed his father in the practice at 1 Hoxton Square, Shoreditch, London.² [Fig.2.] He was very much a part of the local community having been baptised, married and ultimately buried at the church of Saint Leonard's, Shoreditch. [Fig. 3.] Parkinson was sixty two years of age when his essay was published. By that time he had already written accounts of many medical conditions, including hernia, gout, typhoid fever and appendicitis. As well as being a recognised authority on geology and palaeontology³, he was involved in political initiatives to improve the lot of ordinary people, and ran considerable personal risks in writing political pamphlets. In 1785, at the age of thirty, he attended lectures on surgery delivered by the eminent surgeon John Hunter which he took down in shorthand. Hunter never published his lectures and no records of his notes remain but in 1833 Parkinson's son,

John, who had inherited the practice, published an edited version of the lectures from his father's notes.⁴ The frontispiece to the publication gave James Parkinson's work in geology as his main claim to scholarly recognition. [Fig. 4.]



Fig. 3. St Leonard's Church, Shoreditch

In 1955 a book was published to mark the bicentenary of Parkinson's birth.⁵ This book, edited by Macdonald Critchley, contained chapters on James Parkinson's life by WH McMenemy, a facsimile of *An Essay on the Shaking Palsy*, an account of the pathology of Parkinson's disease by JG Greenfield, and a clinical analysis of the 'paralysis agitans' syndrome by FMR Walshe. All these authors were authorities in the field. This book answered many of the questions posed by Parkinson in 1817 which had been clarified by the development of new methods of studying diseases of the nervous system, particularly their neuropathology. Two types of lesion in the brain stem were identified as being specific to Parkinson's disease: the de-pigmentation of the substantia nigra and, in a proportion of cases, the presence of Lewy bodies. There were also lesions in other parts of the brain stem and cerebrum. Three major aetiological forms were recognised: the most common type, idiopathic parkinsonism, in which the aetiology was unknown; arteriosclerotic parkinsonism in which vascular disease underlay the syndrome; and post-encephalitic parkinsonism in which the syndrome followed an episode of encephalitis lethargica. Less common causes were manganese poisoning, syphilis, and poisoning by carbon monoxide. This publication was particularly important because it outlined knowledge of Parkinson's disease at a time when research was about to enter a new era. More recently poisoning by methylphenyltetrahydropyridine [MTPT], an occasional contaminant of a drug of addiction, has been added to the list, together with drug-induced parkinsonism which is usually temporary. A later paper on the diagnosis and pathology of parkinsonism showed that the number of alternative diagnoses was increasing and that assumptions as to aetiology were hazardous.⁵ Many psychiatric complications of the syndrome have also been described.⁷

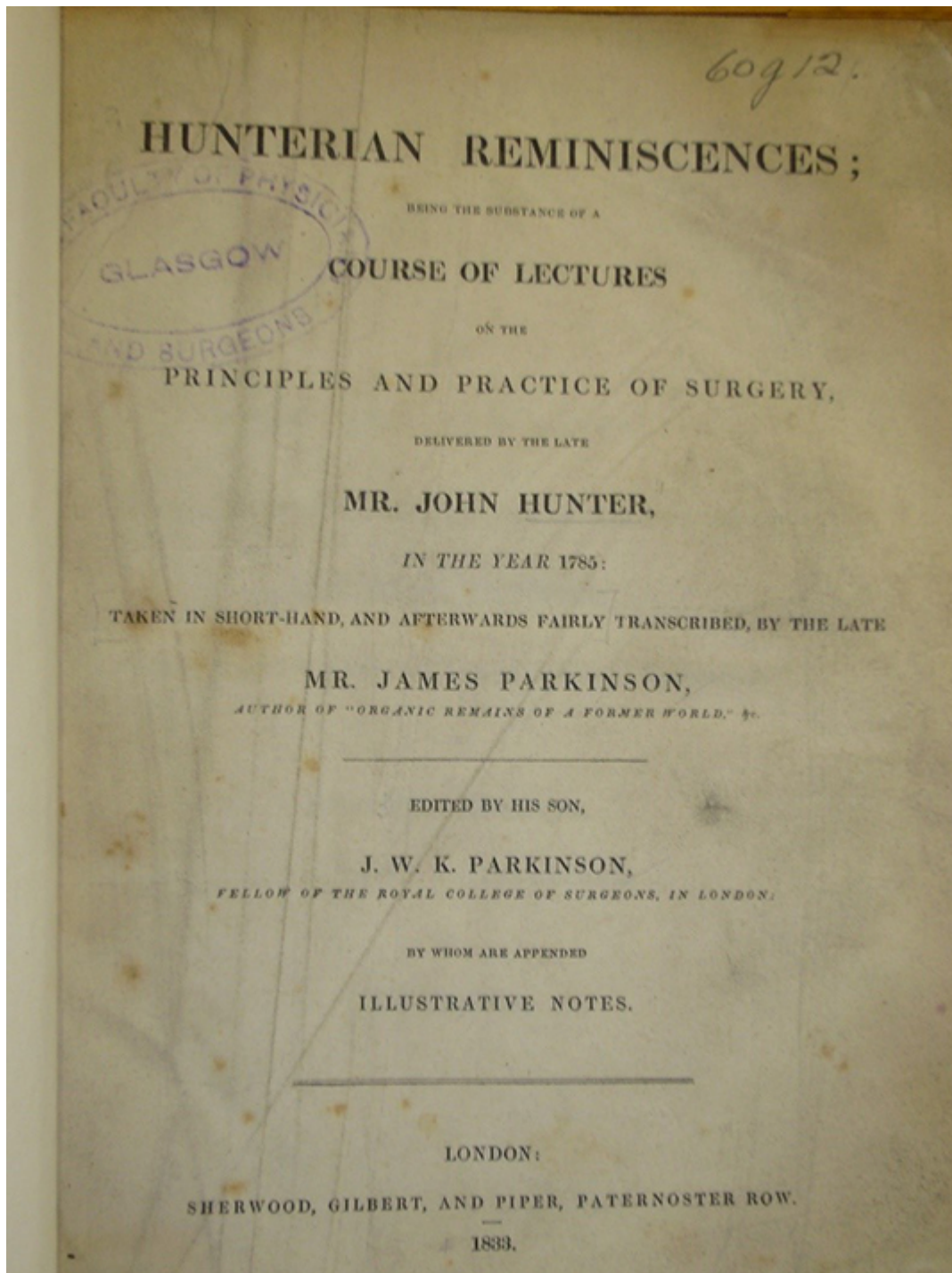


Fig. 4. Frontispiece, *Hunterian Reminiscences*.

After the Second World War methods became available which permitted the study of chemicals in the brain thought to be neuro-transmitting agents. Dopamine concentrations in the brain stem were found to be reduced in Parkinson's disease. Changes in the concentration of neurotransmitters in the brain were also implicated in some psychiatric disorders. It was postulated that 5-hydroxytryptamine was reduced in parts of the brain in some depressive conditions and concentrations of dopamine were increased in schizophrenia. New drugs effective in treating schizophrenia frequently produced the syndrome of parkinsonism as an unwanted effect; indeed it was suggested that it was necessary to induce parkinsonism to

obtain the desired clinical effects. New developments in research revealed unexpected and little understood links between psychiatric disorders and disorders of movement.

The finding that dopamine levels were reduced in the brain stem of patients with Parkinson's disease led to a new treatment for the condition; the administration by mouth of the dopamine precursor levodopa.⁸ The early reports of the effectiveness of this treatment were confirmed and subsequently post-mortem examinations revealed that patients treated with levodopa showed evidence of restoration of dopamine levels in the brain. Parkinson's disease is most unusual among medical conditions in that an understanding of its pathophysiology led to an effective treatment. There were many unwanted effects of treatment, the most dramatic occurring in patients who had suffered for years from post-encephalitic parkinsonism, being released from an immobile state into a condition akin to mania.⁹ Most studies reported that levodopa was more likely to precipitate depression of mood as well as a variety of other psychiatric symptoms. Too high a dosage of levodopa in the treatment of Parkinson's disease leads to choreiform movements resembling those seen in Huntington's disease. Conversely patients with Huntington's disease treated with reserpine or tetrabenazine, both of which cause a reduction in brain amines, may develop parkinsonism and depression of mood.

There have been many reports of dementia accompanying Parkinson's disease but it has been unclear whether this should be regarded as an intrinsic part of the syndrome.¹⁰ In the post-war period there have been three distinct explanations of the finding of dementia in patients suffering from Parkinson's disease: that it was an incidental finding due to a new pathology; that it was a form of sub-cortical dementia¹¹; or that it was due to an interaction between biological and environmental factors.^{12 13} There is now evidence that patients with Parkinson's disease develop dementia in a substantial proportion of cases especially in the later stages of the disease. This has been demonstrated in a number of rigorously controlled studies conducted in different parts of the world. After suffering from the disease for ten years approximately 40% of patients fulfil DSM III R criteria for dementia and the proportion affected rises with the length of illness and increasing age.¹⁴ The occurrence of dementia reduces life expectancy, and, more surprisingly, the presence of depression reduces life expectancy even more.¹⁵

The story of the 'Shaking Palsy' is one of the evolution of a disease: the recognition of its main features; elucidation of its pathology; study of its epidemiology; the development of a range of new treatments; and the description of many associated symptoms, some of which are due to the effects of treatment. In more recent years the story has progressed to include knowledge of the course and prognosis of the disease, the recognition of many sub-types and related disorders, and the finding that Lewy bodies are not specific to Parkinson's disease. In spite of these developments the syndrome of parkinsonism has survived with a central group of patients who have a progressive degenerative condition of unknown cause, known as idiopathic parkinsonism. The shaking palsy has been the focus of intensive research around the world, has stimulated diverse therapeutic efforts and led to a better understanding of neurological and psychiatric conditions. We are indebted to Parkinson for his contribution to neurology and psychiatry, as well as to medicine at large, achieved at a time when research in medicine was almost unknown.

Acknowledgments

I am grateful to the Royal College of Physicians and Surgeons of Glasgow for the use of their library and for the kind assistance of the library staff, and to Francis Maunze, archivist at the RCPsych, for providing the illustrations.

Biographical note

Richard Mindham is Emeritus Professor of Psychiatry at the University of Leeds. He qualified at Guy's Hospital in 1959 and spent much of his working life in Leeds. In 2004 he completed a Masters in History and Theory of Architecture. He now lives in Glasgow.

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From Gulags to Psychiatric Wards: How the abuse of psychiatry became a vital method of political repression in the former Soviet Union – Darren Bell

Introduction

*"A crime is a deviation from the generally recognised standards of behaviour frequently caused by mental disorder ... To those who might start calling for opposition to Communism on this basis, we can say that clearly the mental state of such people is not normal."*¹

In a 1959 speech, Nikita Khrushchev, premier of the Soviet Union, made clear that political opposition to the communist ideology was grounds for a psychiatric diagnosis. Having previously made claims that the Soviet Union had ended the gulag forced-labour camp system for political prisoners, the Communist Party needed new ways of controlling the population. Abusing psychiatric diagnoses to discredit ideological dissenters and remove them from society appears to have become one of the most important methods of political repression.¹ Dutch human rights activist Robert van Voren defined the political abuse of psychiatry as 'the misuse of psychiatric diagnosis, treatment and detention for the purposes of obstructing the fundamental human rights of certain individuals and groups in a given society'.²

Soviet psychiatry: a brief history

The Bolshevik Revolution of 1917 transformed the power structure, and progressive psychiatrists were amongst the first groups of professionals to lend their support to the new regime. Leading psychiatrists were quickly promoted within the medical administration; even in the early days of Soviet society there existed an unsteady alliance between the psychiatric profession and political institutions.³ During the premiership of Joseph Stalin, institutionalisation in a psychiatric hospital was often considered by the profession to be a way of protecting people from being sent to gulags, where they may be punished more harshly. This changed overnight in the early 1950s when Dr Daniil Lunts was appointed head of the Political Department at the Serbsky Institute for Forensic Psychiatry.^{1,4} Following the claimed closure of gulags, a new mechanism of control was necessary: political psychiatry was turned into an instrument of repression against those who opposed the existing social order.⁵ Most evidence indicates that the abuse of psychiatry became a systematic form of repression under Khrushchev's premiership in the late 1950s and early 1960s.² This practice burgeoned until, by the late 1970s, roughly one-third of all political dissident cases were processed through the 'politically insane' procedure.¹

The factors providing the conditions for political psychiatry to mature in the Soviet Union

With the spread of democracy and free speech across the world, Ronald Leifer argued that authoritarian states required 'a new social institution that can control and guide conduct

without conspicuously violating publicly avowed ideals of freedom', and that psychiatry assumed this function in the Soviet Union.⁷ Critics of psychiatry believed that psychiatrists may covertly or overtly display their political stance when managing those whose behaviour has been considered unacceptable, forcing those individuals to conform to ideals of how one should act within a community. Additionally, within the Soviet Union, psychiatrists depended on the political institution for their livelihood; remaining in good favour with the Communist Party ensured job security, thus the interests of the political organisation at times took precedence to those of the patients.⁴ Finally, throughout the existence of psychiatry in the Soviet Union, hospitalisation without consent was reserved for cases in which the patient was deemed to be 'dangerous'. Without reliable criteria to predict how 'dangerous' a patient would be, studies showed that Soviet psychiatrists played very safe when doubt existed about a patient's dangerousness, opting significantly more often for compulsory hospitalisation.⁸ The lack of objective evidence and criteria available to those working in it left it vulnerable to mistake and abuse.

In 2002, Professor Richard Bonnie argued that even in a liberal, pluralistic society, involuntary psychiatric hospitalisation carries an intrinsic risk of misuse. The totalitarian Communist regime, intolerant of any political dissent, magnified this risk.⁶ Widespread propaganda facilitated the belief that the only logical explanation why anyone would not fully support the best socio-political system in the world was mental illness.² Furthermore, within a centrally-ruled totalitarian state under a communist ideology, the official ethos of collectivism leads to intolerance of deviance from conventional norms and values. In the medical profession, doctors were made to swear the Oath of the Soviet Doctor instead of the Hippocratic Oath, indicating that their loyalty was primarily to the Communist Party, rather than to ethics or patients.^{2,9} Part of the Oath of the Soviet Doctor reads: 'In all my actions to be guided by the principles of the Communist morality ... and my responsibility to the people and the Soviet state', indicating that priority was to be granted to the collective over the individual.⁹ Finally, KGB Chairman Yuri Andropov and his associates helped to develop the political abuse of psychiatry as a systematic means of repression; KGB offices received detailed instructions from them on how psychiatry may be used to remove 'hostile elements' from society.²

A core group of psychiatrists worked in collusion with the Communist Party to develop and implement a system to treat political dissenters as mentally ill.² Andrei Snezhnevsky, director of the Institute of Psychiatry of the USSR Academy of Medical Sciences, understood that gaining the approval of the Communist Party would propel him to professional success, and he used the totalitarian ethos of Soviet society to label political opposition as a manifestation of mental illness. He coined the term 'sluggish schizophrenia', which he said could present as a normal mental state on psychiatric examination,¹ resulting in ideas of reforming society and political dissent to become symptoms of a psychiatric disorder.² His views on psychiatry were largely unchallenged; those who questioned him generally found themselves unemployed or in exile to Siberia. The Communist Party glorified his 'scientific discoveries', instructing that they be taught to future psychiatrists.¹ This elite group of psychiatrists had full access to the *spets-khran*, special closed departments of medical literature where genuine western scientific studies could be found, and they were allowed to travel to international conferences.¹ They were still more than willing to work alongside the Communist Party to implement a state-directed policy of psychiatric abuse, and were rewarded with significant salary increases and other privileges, including access to luxury goods stores and second homes.⁴

Most scholars consider the average psychiatrist working in the Soviet Union to have had limited knowledge of the political abuse of psychiatry. However, where they were aware of these abuses, fear seems to be the most cogent factor in ensuring their passivity. Dissenting psychiatrists found themselves shunned by colleagues and investigated by the KGB, often getting arrested and spending time in exile. An émigré psychiatrist explained that Soviet society was one of ‘perfect understanding’; on learning that a prospective patient is a KGB political offender, they knew to label the patient as not responsible or insane and recommend compulsory treatment.⁴ Additionally, many psychiatrists grew up surrounded by communist propaganda and were unfamiliar with the world of psychiatry, exposed only to the Soviet schools of thought, thus limiting their ability to distinguish political dissent from genuine illness.¹

Some political scientists have surmised that socialist and communist regimes are particularly vulnerable to use of political psychiatry for repression. Outside the Soviet Union, most reports of the political abuse of psychiatry implicate other socialist or communist regimes, such as eastern European countries¹¹ and the People’s Republic of China.¹² Totalitarian monistic political views characterised all countries in which state-directed policies of political psychiatry became widespread; dissent was seen as a significant threat which needed to be forced out of society for the existing political order to maintain complete dominance over the people.¹³ This aligned with Khrushchev’s ideology; antisocialist thought in socialist society was impossible, and dissidence could be explained only by blaming western values, the legacy of the bourgeoisie or mental illness.¹

Conclusions

In 1989 at the World Congress of Psychiatry, the Soviet delegation admitted that abuse of psychiatry had taken place and that political hospitals were an egregious mistake. As a relatively new specialty, psychiatry had been particularly vulnerable to misuse and abuse. The average psychiatrist was kept in line by fear and dependency; ignoring the wishes of the Communist Party meant rebelling against their only source of income and livelihood, and they risked social and professional ruin. Most importantly, this culture was able to exist because the Soviet Union was a completely totalitarian state. The power of the Communist Party was absolute, and ensured by the KGB. Fear, intimidation and corruption replaced free speech and democracy, allowing the political abuse of psychiatry to become a systemic and unchallenged method of repression of dissidence.

Biographical note

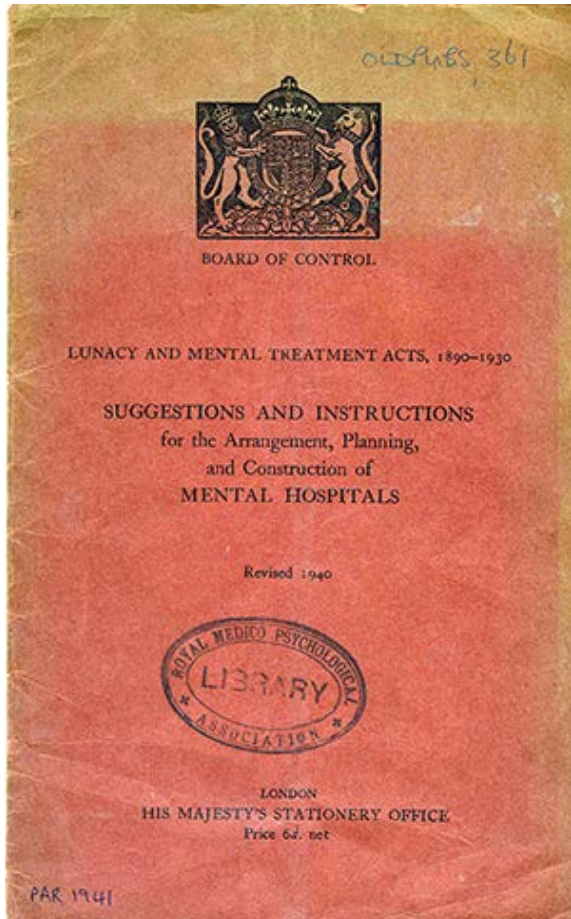
Darren Bell is a final-year medical student at St. George’s University. He is due to graduate in 2017.

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From the RCPsych archives: hierarchies, attitudes and buildings in 1941 – Claire Hilton



The Board of Control, the statutory body overseeing the mental hospitals in England and Wales (1913-1960), revised its *Suggestions and Instructions for the Arrangement, Planning, and Construction of Mental Hospitals* in 1941. Despite its long title, this pamphlet comprises only 24-pages. However, it is full of surprises. I highlight some of them here, and raise some questions about them.

The first surprise is the date: why was the Board publishing this guidance during the Second World War? The Emergency Medical Services requisitioned mental hospitals for war casualties, resulting in overcrowding for their usual patients, which could have prompted thinking about building more hospitals. Nevertheless, building mental hospitals was improbable in the context of limited resources and competing priorities. The desire to plan for after the War, as with William Beveridge's proposals (1942) for a welfare state, could also have prompted the guidance.

Generally, the guidance followed earlier principles: a hospital should have no more than 1000 beds and should be on elevated ground, although not over-exposed to the elements. It should have ample land around: for cultivation (including by the patients), for recreation for patients

and staff, and to provide ‘reasonable seclusion of the buildings and gardens from public view.’ The last may have been to provide privacy for patients, or to protect the public from having contact with them. The pamphlet does not give reasons for recommending the seclusion, but it is compatible with the perception that mentally ill people were ‘other’.

The Board also recommended an ‘early treatment centre’ and ‘convalescent’ homes. Aiming to treat and discharge patients preceded the development of neuroleptics and antidepressants. In the men’s convalescent home, one communal room was to be large enough for a full size billiard table.

Seven per cent of mental hospital beds were designated for ‘senile and infirm’ older people, in line with demographic data. However, this bore little relationship to the statistics that patients over age 65 occupied 15% of all male beds and 21% of all female beds.¹ Other instructions included that wards for older people should be on the ground floor with a walled garden to provide safe outdoor space, a provision which is not universal in 2017. Other facilities included rooms for hydrotherapy, massage, electrical and light treatments, and for ‘continuous baths’.

Another surprise was the size of accommodation recommended for hospital staff (who generally ‘lived in’). It gives insights into hospital hierarchies, with the medical superintendent at the top, and patients at the bottom:

Role	Approx. size	
	sq. feet	m ²
Medical superintendent	3,000	280
Deputy medical superintendent	2,250	209
Other medical officers and chaplain	1,650	153
Unmarried medical officers	300	28 ⁱ
Clerk and steward	1,650	153
Clerk of Works	1,500	139
Head male nurse	1,200	111
Head engineer	1,100	102
Head gardener	1,100	102
Male married nursing/artisan staff	950	88
Matron	950	88
Assistant matron	280	26 ⁱⁱ
Sisters	140	13 ⁱⁱ

ⁱ Each with shared bathroom and common room (but requiring modification should a woman be appointed)

ⁱⁱ In nurses' home

There was no provision for married female nurses.

Wards should have no more than 50 patients, many of whom would have remained in hospital long-term. The 'normal standard of day space is 40 sq ft' (3.7 m²) per patient, slightly more for 'disturbed and more excited' patients, and less for older people. Dormitory bed space was usually 50 sq ft (4.6m²) per person, and single rooms for patients about 85 sq ft (7.8 m²).

Other hospital facilities included a library, lecture rooms, power station, recreation hall, shop, church, mortuary, laundry, bakery and burial ground. These would create a self-contained 'total institution'.²

In summary, the pamphlet tells us about more than just planning and construction; it provides a fascinating insight into the hierarchies within mental hospitals and the types of facilities provided in a 'total institution'.

Acknowledgement

Francis Maunze, RCPsych archivist, kindly provided the illustration.

Biographical note

Claire Hilton is an old age psychiatrist with a strong interest in history of psychiatry and is currently chair of HoPSIG.

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Book review by George Ikkos

Nick Bouras, *Reflections on the Challenges of Psychiatry in the UK and Beyond: a psychiatrist's chronicle from deinstitutionalization to community care* (Pavilion Publishing and Media: Hove, Sussex, 2017)

In Classical Antiquity, the Lacedemonians (Spartans) were renown for their extreme economy with words; hence the designation 'Laconic', which persists to this day, to indicate succinct expression. For example, during the Peloponnesian War, lesser Greek City States had to take sides to support either Athens or Sparta. In his *Histories*, Herodotus recounts the experience of the pro-Spartan ambassadors from the City State of the Aegean island of Samos, when they sought an audience to secure support from their dominant allies. The Spartans found the visitors too wordy and Herodotus records their interaction as follows:

The response of the [Spartan] authorities to this first audience, however was to complain that they could not remember the early section of the speech, and had failed to understand what came after. As a consequence, when the Samians gained a second audience, they [the Samians] simply came in with a sack and said nothing at all, except to comment, 'This sack needs barley-meal'. 'There was no need to say "sack"', came back the reply.¹

Both in person and in print, my compatriot, friend, mentor and collaborator Nicandros (Nick) Bouras [Fig 1], Emeritus Professor of Psychiatry at the *Institute of Psychiatry Psychology and Neuroscience* (IoPPN) London and Director of *Maudsley International*, is laconic. As frontispiece to this book he quotes the 6th century BC mathematician Pythagoras: 'Do not say a little in many words, but a great deal in a few'. In small size, large print and at a less than 250 pages long, the book is packed with detailed information about UK policies, mental health services, academic and clinical psychiatry (especially in South and South-East London) and the people that labored within them from 1974 to today. As a leading clinical and academic psychiatrist in intellectual disability, he is particularly strong on the history, research and clinical services in this field, both in the UK and internationally. Readers will find references to all relevant policies on intellectual disability during the period 1975-2015 in this one resource; also, policies on general adult mental health services. The chronicles of child and adolescent, forensic and old age psychiatry remain for others to write.



Fig. 1

This is the third in a series of autobiographical works that Bouras has penned since retirement from the NHS in 2008, the other two having been written in Greek. The first, *The Aretheion School: a historical chronicle*², is a mostly pictorial tribute to his father, its former headmaster. The second, *Greeks in London*³, is an account of Bouras' experience of the Greek intelligentsia in London from 1974 until the year of the book's publication in 2013. Though each book is intimately related to his personal life and career, their focus is generously directed at others most of the time. All three are heavily based on his impressive personal archives. These have been collected systematically throughout his career and have now been deposited with the library at King's College London.

In *Greeks in London*, Bouras' account included a detailed chronicle of the scandal of the psychiatric asylum on the Aegean island of Leros which was headlined on the front page of the British newspaper *The Observer* in the early 1980s. As that book and the one under present review demonstrate, since those early years he has been at the forefront of development of community psychiatric services both in Greece and the UK. In the NHS, he led the development of the Estia Centre [Fig 2] for people with intellectual disability, a flagship centre with clinical, training and research activities which he discusses in detail in Chapter 10. At present, he is actively involved in evidence based services development and quality assurance internationally. His approach is rooted in enlightenment humanism and reason, and directed by evidence, not ideology and slogans.

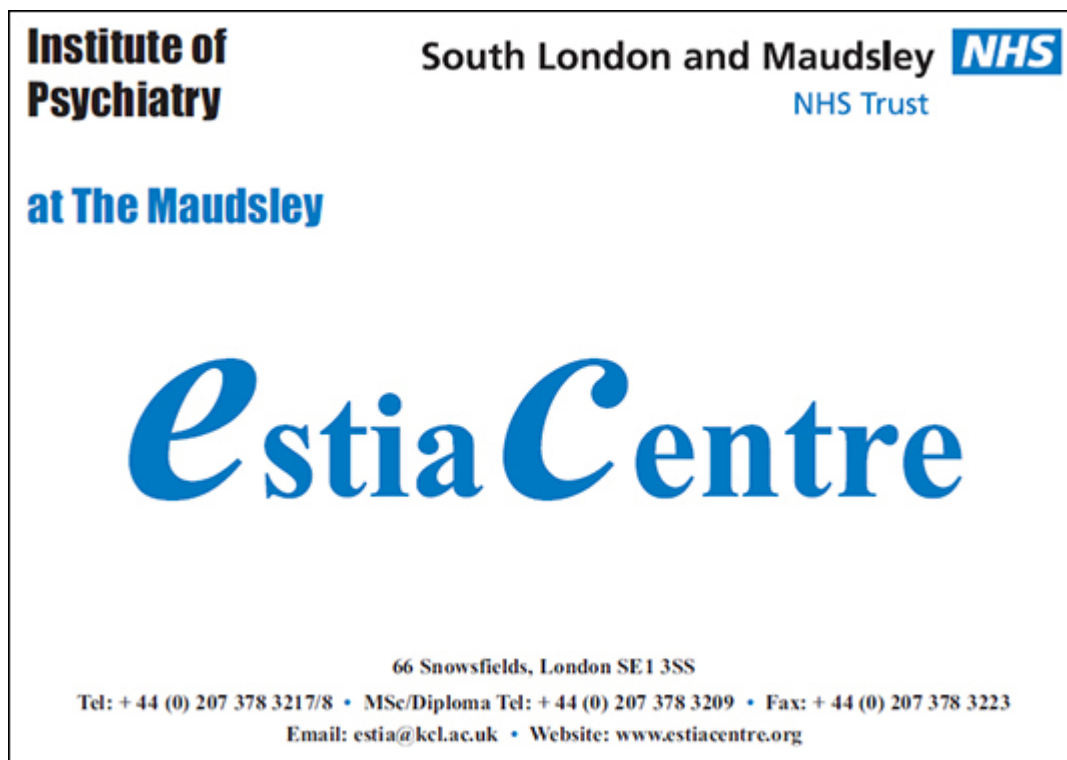


Fig. 2

Bouras is a reliable witness. Those of us who have worked in NHS mental health services during the period he chronicles, will immediately recognize the fidelity of the picture he paints. Early on after arriving to the UK in 1974, he joined the centre of excellence that was Guy's Medical School Department of Psychiatry in the 1970s. It was headed by Jim Watson, one of the first London professors of psychiatry, who emerges from these pages as a

psychiatric ‘renaissance man’ and truly inspirational figure. From such beginnings, he describes the ambitions, frustrations, achievements and disappointments of de-institutionalisation and community care, including the constantly changing administrative and management structures. Though he is not necessarily negative in his overall evaluation, his verdict below, sadly, is widely applicable, well beyond NHS intellectual disability and adult mental health services:

It is amazing how all these complexities were allowed to mushroom in the NHS, creating an unbelievable bureaucracy and fragmentation that hampered the delivery of care in a health system admired around the world for providing easy access to services that are free at the point of contact. In my experience of working in the NHS for over 35 years, I believe that the organizational problems were complicated not only by the lack of funding, but equally, if not more so, by the personalities involved. Considering how many problems we experienced in a small service such as ours, I wondered what would happen in other services in the NHS as a whole. (p101)

Reflections on the Challenges of Psychiatry in the UK and Beyond will be an indispensable tool for future historians of psychiatry and mental health services for the period 1975-2015, perhaps unique in its detail of reference to the experience of a talented and committed academic and clinical psychiatrist during this time.

That said, where next?

We need to study and understand the history of psychiatric de-institutionalisation and community care in the wider political economic context of the changing UK society during the years of neoliberal ascendancy from 1979 till the crisis of 2010. De-institutionalisation and community care were first conceived in the late 1950s and early 1960s at the height of the political economy of the welfare state and the radical advocacy of social liberalism⁴. They were implemented, however, during the years of market fundamentalism and a backlash from conservative (Tory and New Labour) authoritarianism⁵. Some of the frustrations and shortcomings that Bouras documents are probably best explained in the light of a broader understanding of social-historical developments in UK.

Now that we have moved ‘From Community to Meta-Community Psychiatry’^{6, 7} wider reflection may prove invaluable, if we wish to avoid past hyperbole and error in the new phase. The RCPsych History of Psychiatry Special Interest Group (HoPSIG) is in a superb position to support and contribute to such a project through facilities, access to expertise and ability to hold relevant academic events and other activities.

Biographical note

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