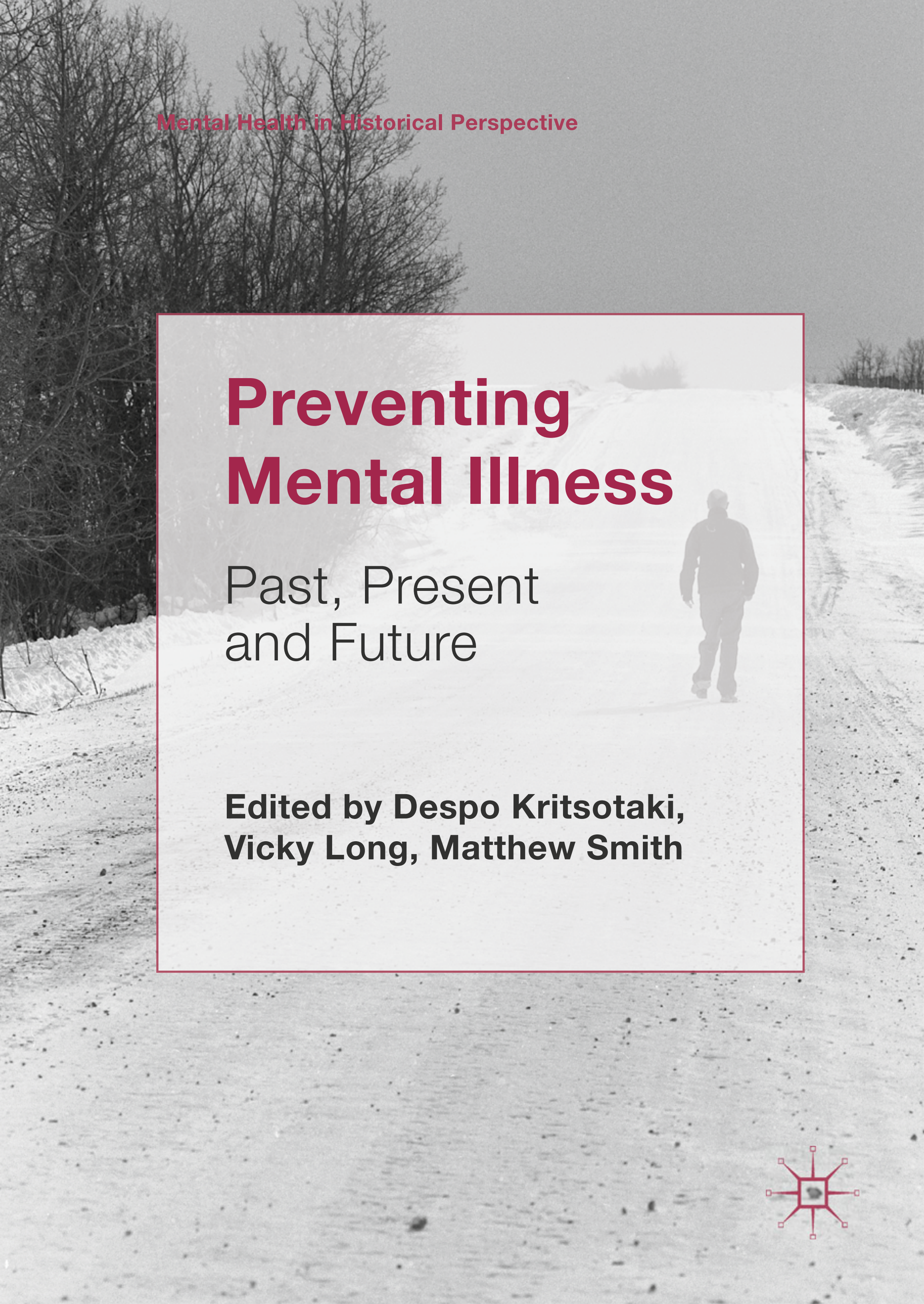

Mental Health in Historical Perspective

Preventing Mental Illness

Past, Present and Future

Edited by Despo Kritsotaki, Vicky Long, Matthew Smith

Mental Health in Historical Perspective

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FOREWORD

The elimination of mental ill-health has long been a preoccupation of governments, as well as the medical and social care professions. The drivers for change have varied considerably over the last 150 years. Included in this long list has been the theory of natural selection and the drive for perfection, concepts of mental 'hygiene', psychiatry as social control, ideas around gender roles and their contribution to mental ill-health and cultivating resilience in children, investing in perinatal nutrition and intervening to arrest intergenerational trauma. Each of these innovations and developments has been seen—at least by some—as being a 'silver bullet'[1]: the single solution to what is an intricate individual and societal experience. Mental ill-health is complex. The causes are both global and individual. The effects are dependent on a range of factors- some protective and some less so. The public mental health challenge is to recognise both, to move from a focus on what is 'wrong' to what has happened, and to address global and individual need.

Mental health continues to be the poor relation to physical health: always under- funded, always overlooked. Distress is still seen as a weakness by societies across the world, including those who experience it—particularly men—exacerbating an already difficult experience. Systems are geared towards identifying the deficits in people's experience: mental

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[1] Sarah A. Sheard, "Lifecycle of a Silver Bullet," *The Journal of Defense Software Engineering* (July 2003): 28–30, http://freyr.webpages.com/Life_Cycle_of_a_Silver_Bullet.pdf, accessed 25 February 2018.

health as a barrier to employment, education or living a fulfilling life; reinforcing what cannot, now, be done as a result. For example, a broken bone can be fixed with the application of skill and care. Physical recovery is the experience of returning to full fitness after that challenge. Human psychology is different, however. Our experiences of the world cement some forms of thinking whilst undermining others. The key interface in this relationship is how individuals and systems see the world. This is a fundamental challenge for public mental health, but there is no simple solution. Bazalgette's answer to endemic disease and death in London—and the Big Stink—was the creation of a complex and comprehensive sewerage system.[2] At one fell stroke, he solved many of the capital's public health challenges, enabling the city to continue to flourish. In comparison, people experiencing psychological distress may describe similar experiences that can be quantified and assessed (symptoms of depression or anxiety, for example), but the qualitative experience of those 'things' is unique, informed by the combination of unique experiences. Ascribing blame to a single *bête noir* in public mental health—comic books in the middle of last century or violent video games in the aftermath of mass shootings in the US—is a distraction and prevents progress.

One of the major public health challenges in the developed world, and increasingly elsewhere, is how society, and individuals within it, views and manages distress. Distress is a common human experience and is qualitatively different for each person who experiences it. That experience is informed by trauma, the connections, and the skills developed over time to manage its consequences. Evidence from the expanding literature on adverse childhood experiences appears to support the view that trauma is common—perhaps universal—but that the response to that trauma is individual. Protective factors appear to vary from the simple (the importance of 'one good adult' is explored elsewhere[3]) to the structural (see the social determinants for mental health[4]).

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[2] Stephen Halliday, *The Great Stink of London: Sir Joseph Bazalgette and the Cleansing of the Victorian Metropolis* (Stroud: Sutton, 2001).

[3] Barbara Dooley and Amanda Fitzgerald, "MyWorld Survey: National Study of Youth Mental Health in Ireland," Headstrong and UCD School of Psychology (2012), http://researchrepository.ucd.ie/bitstream/handle/10197/4286/My_World_Survey_2012_Online%284%29.pdf?sequence=1, accessed 28 May 2018.

[4] World Health Organization and Calouste Gulbenkian Foundation, *Social Determinants of Mental Health* (Geneva: World Health Organization, 2014).

Prevention of mental ill-health is a major challenge for all societies. But, constructions of mental health are complex and disputed. There is evidence from years of intervention that, for example, drug treatments on their own are less successful than those that combine with psychological interventions.[5] Medicine and professional therapy, however, are not the only answer. There is growing evidence from the recovery movement across the world that creating connections, and dealing with the increasing isolation in modern society, have a greater impact on longer term mental health than drug treatment alone.[6] Creating those connections with people who have had similar experiences can have a significant impact on the locus of control and the experience of stigma that many people encounter. Lived experience is now at the centre of many approaches to mental health prevention and treatment. Without the radical approaches by R.D. Laing[7] and others who highlighted the connection between social control and psychiatry and the importance of breaking those shackles, crucial developments in prevention and treatment, such as peer led services and recovery colleges, may never have been developed and a crucial element in understanding the complexity of public mental health, the lived experience, would be missing.

The reality is that many of us who have experienced distress which results in transient mental ill-health will experience it again in the future. What is crucial is what we have learned about ourselves through that experience, to help us manage that experience the next time. Distress is ultimately one of the most common experiences in humanity. Modern pressure to live up to idealised visions of what constitutes a happy life

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[5] For example, Charles B. Nemeroff et. al., “Differential Responses to Psychotherapy versus Pharmacotherapy in Patients with Chronic Forms of Major Depression and Childhood Trauma,” *Proceedings of the National Academy of Sciences of the United States of America* 100, no. 24 (2003): 14293–96.

[6] Larry Davidson, Jaak Rakfeldt, and John Strauss, *The Roots of the Recovery Movement in Psychiatry: Lessons Learned* (Oxford: Wiley-Blackwell, 2010); LeRoy J. Spaniol, Larry Davidson, and Courtenay Harding, *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice*, vols. 1 and 2 (Boston, Mass: Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Sciences, Boston University, 2005–2006); and Mary Leamy et al., “Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis,” *The British Journal of Psychiatry* 199, no. 6 (2011): 445–52.

[7] R. D. Laing, *The Voice of Experience: Experience, Science and Psychiatry* (Harmondsworth: Penguin, 1982).

adds to that burden. Most interventions to date seek to alleviate an already occurring and complex mental health circumstance. Preparing our young people with the skills and capabilities to be resilient or to seek support at the earliest possible stages requires the intervention of schools, teachers and community workers and even further than that: society as a whole has a vital role to play in this process.

The information we now have about the impact of childhood trauma on our adult lives tells us many people live with a traumatic past and live very healthy lives. They do so by being connected to others, fostering hope in themselves and others and having a keen sense of identity of the person they are as well as what they want to be. We also know that a number of people in the caring professions have experienced significant trauma in the past: that the damaged person seeks to resolve their damage by helping others is a very common theme. Prevention of mental ill-health has at its heart systematic and societal change that makes conversations about distress more common and reinforces the belief that talking about that experience is not a sign of weakness but of strength, and that experiencing any form of distress can be a barrier but it also creates skills that we often do not recognise.

It may be a greater challenge to prevent mental ill-health than it is to minimise its impact and duration. How resilient we are to distress appears to be a factor of how connected we are to others.[8] If we are truly to live mentally healthy lives, perhaps we should look to the mental health learning from the recovery colleges' movement,[9] not to prevent the distress that will inevitably come, but to learn from the experience for the next time. Because recovery and resilience are very personal experiences: what works for one person may not work for everyone, although the experience of a peer may give you confidence to find your own way.

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[8] See Leamy et al., "Conceptual Framework for Personal Recovery in Mental Health."

[9] Lori Ashcraft and William A. Anthony, "A story of Transformation: An Agency Fully Embraces Recovery," *Behavioral Healthcare Tomorrow* 14, no. 2 (2005): 12–22; Rachel Perkins and Julie Repper, "Recovery versus Risk? From Managing Risk to the Co-production of Safety and Opportunity," *Mental Health and Social Inclusion* 20, no. 2 (2016): 101–109.

Public mental health is one of the most important issues for our society. Many things have changed since Freud began to explore psychoanalysis and the discovery of the first effective drug treatments. As this book will demonstrate, there is much more still to be done and to be learned.

Glasgow, UK
Frank Reilly
Director of the Scottish Recovery Network

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CHAPTER 1

Introduction

Matthew Smith, Vicky Long, Oonagh Walsh and Despo Kritsotaki

Anyone who has crossed a railway bridge, walked through a level crossing or spent time at a train station in the UK will have encountered carefully placed posters with one aim in mind: to prevent the person reading it, if they were so minded, from leaping onto the tracks when a train approaches, and killing themselves. Produced by Samaritans, a UK-based suicide prevention charity, the posters have messages such as 'We're in your corner', 'Need to talk to someone?' and 'Desperate? Call us. We listen'. Samaritans was founded in London in 1953 by vicar Chad Varah (1911–2007) and was the first crisis hotline established

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'to befriend the suicidal and despairing'.[1] Today, there are over 200 branches of the charity in the UK and Ireland.

The strategy of placing Samaritans posters in the vicinity of speeding trains is no coincidence. In 2016/2017, 238 people in the UK took their own lives on the railway; during the same period, there were over 2500 suicide attempts on the railway. Although these figures amount to only a fraction of the over 6000 suicides that occur annually in the UK, the very public nature of these deaths, which can result in hundreds of people being traumatised by what they have experienced explains why Samaritans has addressed this particular issue in their Rail Suicide Prevention Programme (RSPP) from 2010 onwards. RSPP provides training for railway staff who might come in contact with suicidal individuals, providing post-incident support to staff and travellers, and community support at high risk locations, while working with the media to ensure responsible and sensitive reporting of rail suicides. So far, 16,000 railway staffs have been trained, and 400 of these individuals have successfully intervened in an attempted suicide.[2]

Although RSPP has contributed to a reduction in suicides, winning numerous industry and charity awards along the way, other initiatives to prevent suicide have not been so successful. As Theodore Jun Yoo describes in the introduction to *It's Madness*, Seoul, South Korea partnered with Samsung Life Insurance and advertising agency Cheil Worldwide in 2012 to prevent people from jumping off Mapo Bridge, a common suicide spot in a country that has one of the highest suicide rates in the world.[3] The initiative involved placing interactive LCD panels on the bridge's guard rails, which illuminated short inspirational messages and affirmational images when the handrails were touched. A sculpture showing one person comforting another on a bench was also erected. Sadly, however, the 'Bridge of Life' project backfired, with suicide rates quadrupling after the features were introduced. According to Yoo, critics of the 'Bridge of Life' argued that not only did the trite

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[1] Chad Varah, *Samaritans: Befriending the Suicidal* (London: Constable, 1985); "The History of Samaritans," https://www.samaritans.org/about-us/our-organisation/history-samaritans, accessed 13 March 2018.

[2] https://www.samaritans.org/for-business/rail-industry-suicide-prevention-programme, accessed 17 March 2018.

[3] Theodore Jun Yoo, *It's Madness: The Politics of Mental Health in Colonial Korea* (Berkeley: University of California Press, 2016), 4.

messages exacerbate the shame and anger felt by those contemplating suicide, but the broader campaign did nothing to address the 'core problem– the profound social stigma of seeking help from mental health professionals, which leaves suicide as the only conceivable escape'.[4] The interactive panels were soon removed with the promise that a better prevention programme would soon be introduced.[5]

These examples bring to mind two of the challenges inherent in attempting to prevent mental illness. Although suicide is a complex phenomenon (see the contribution of Mikko Myllykangas in this book), it has been commonly viewed by clinicians and social scientists as a form, symptom and/or consequence of mental illness. The above-mentioned examples highlight this connection and bring to mind two of the challenges inherent in attempting to prevent both suicide and mental illness. The first is simply that neither the prevention of suicide nor the prevention of mental illness is easy or straightforward. The interactive features of the Mapo Bridge probably seemed quite sensible to many intelligent, well-informed people when they were being introduced (in fact, the 'Bridge of Life' project won a number of advertising awards). And yet, they achieved the opposite of what was intended. Although the Samaritans' efforts to reduce railway suicides have been more successful, their efforts have not resulted in a precipitous decline in railway suicides. Network Rail's figures indicate that from 2011 to 2014, when RSPP was in place, the number of suicides actually increased from 211 to 288.[6] While the numbers decreased in 2015 and 2016, it is difficult to determine how much of this has been due to RSPP or to other factors, such as an improving economic picture in the UK and reduced unemployment.[7] Moreover, it is important to emphasise the sheer amount of effort that has been expended to put RSPP into place. It costs a great deal in time and resource to deliver a full-day suicide prevention workshop to 16,000 railway employees, to produce pamphlets and posters and to provide

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[4] Ibid.

[5] Ibid., 156.

[6] https://cdn.networkrail.co.uk/wp-content/uploads/2016/11/Incidents-of-suicide.xlsx, accessed 19 March 2018.

[7] G.D. Batty, M. Kivimäki, S. Bell, C.R. Gale, M. Shipley, E. Whitley, and D. Gunnell, "Psychosocial Characteristics as Potential Predictors of Suicide in Adults: An Overview of the Evidence with New Results from Prospective Cohort Study," *Translational Psychiatry* 8 (2018), https://www.nature.com/articles/s41398-017-0072-8.

post-incident support to both staff and travellers. In addition to Network Rail, RSPP is supported by the British Transport Police, the Association of Train Operating Companies, the Rail Safety and Standards Board and the four relevant trade unions. Much more difficult to calculate is the seven decades of experience that Samaritans has had in suicide prevention, which has informed the development of the programme. All of this expertise, dedication and compassion add up to a great deal, but people still end their lives on the railways.

Second, even though preventing suicide is a difficult, delicate endeavour, it pales in comparison to the challenge of preventing mental illness more generally. Suicide is but one act and one that most people struggling with mental illness do not contemplate. Preventing this one act does not make the problems leading up to the attempt disappear. Mental illness, in contrast, consists of a constellation of different experiences and symptoms caused by a multitude of biological, psychological and social factors and mediated by the complex cultural context in which it occurs. Making matters even more difficult, researchers, clinicians and patients do not always agree on what constitutes a mental illness, let alone what causes one.[8]

Attention deficit hyperactivity disorder (ADHD) provides an interesting case in this regard. ADHD emerged in the late 1950s as a distinct disorder and quickly became the most common childhood psychiatric disorder.[9] The predominant conceptualisation of ADHD is that it is a genetic, neurological disorder that is not really preventable, but, instead, is treatable with stimulant drugs. Alternative explanations for the disorder, however, suggest something quite different. There are many commentators, for instance, who have questioned the very validity of ADHD as a psychiatric disorder or have argued that it is over-diagnosed.[10] The global spread of what emerged as an American disorder has prompted

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[8] For a recent discussion of the nature of mental illness, see John Swinton, "Unravelling 'Mental Illness': What Exactly Are We Talking About?" in *Migration and Mental Health: Past and Present*, ed. Marjory Harper (Basingstoke: Palgrave Macmillan, 2016), 21–35.

[9] Matthew Smith, *Hyperactive: The Controversial History of ADHD* (London: Reaktion, 2012).

[10] Probably the best example of such critiques has come from psychiatrist Allen J. Frances, the chairperson of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Allen J. Frances, "ADHD Is Overdiagnosed, Here's the Proof," psychologytoday.com (23 May 2016), https://www.psychologytoday.com/us/blog/saving-normal/201605/adhd-is-overdiagnosed-heres-proof, accessed 22 March 2018.

further critiques about how it is diagnosed and why.[11] Supporters of the rights-based neurodiversity movement have also claimed that by over-diagnosing ADHD and other disorders, particularly autism, we discriminate against 'non-neuro-typicals', individuals who present neurological differences of various kinds.[12] Some might argue, therefore, that the best way to prevent ADHD (and many other psychiatric disorders) is simply not to diagnose it so much.

Moreover, there is a significant amount of evidence to suggest that hyperactive, inattentive and impulsive behaviour in children can be triggered by a wide range of social and environmental factors, ranging from synthetic food chemicals and lead exposure to family distress and not enough time spent exercising or in natural surroundings.[13] If this is the case, preventing ADHD is absolutely possible, but determining what is specifically causing such behaviour problems in individual children (or their over-diagnosis) is an arduous task. It may well be easier for a parent to seek out a prescription for Ritalin. But is this the right course of action for the child? And does it help society more generally learn about the causes of mental illness? Probably not.

The rapid increase in the global diagnosis of mental disorders during recent decades compels both historians and mental health professionals to consider such issues more seriously. The World Health Organization (WHO) estimates that 300 million people worldwide suffer from depression alone, making it the leading form of disability globally.[14] Although questions remain about how conditions such as depression are diagnosed and distinguished from 'normal' moods and emotional states,[15] the social and economic costs of mental illness have prompted WHO

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[11] Matthew Smith, "Hyperactive Around the World: The History of ADHD in Global Perspective," *Social History of Medicine* 30, no. 4 (2017): 767–87.

[12] Simon Baron-Cohen, "Neurodiversity: A Revolutionary Concept for Autism and Psychiatry," *Journal of Childhood Psychology and Psychiatry* 58 (2017): 744–47; Bonnie Evans, "The Autism Paradox: How an Autism Diagnosis Became Both a Clinical Label and an Identity; a Stigma to Be Challenged and a Status to Be Embraced," *Aeon*, https://aeon.co/essays/the-intriguing-history-of-the-autism-diagnosis, accessed 29 March 2018.

[13] Smith, *Hyperactive*, 127–49; Matthew Smith, *An Alternative History of Hyperactivity: Food Additives and the Feingold Diet* (New Brunswick, NJ: Rutgers University Press, 2011).

[14] World Health Organization, "Depression: Fact Sheet," http://www.who.int/mediacentre/factsheets/fs369/en/, accessed 29 March 2018.

[15] Allan V. Horwitz, "The DSM-5 and the Continuing Transformation of Normal Sadness into Depressive Disorder," *Emotion Review* 7 (2015): 209–15.

to prioritise prevention as part of its *Mental Health Action Plan: 2013–2020*.[16] What is completely absent from this plan and, indeed, most other attempts to prevent mental illness, is any awareness that preventive approaches to mental health are nothing new, and that it might well be possible to learn from such historical attempts which approaches are worth considering in future and which are best confined to the past.

Context and Historiography

The prevention of mental illness, for instance, was central to humoral medicine and has been a topic addressed by historians. In *Anatomy of Melancholy* (1621), Robert Burton (1577–1640) provided numerous ways in which to prevent bouts of melancholia, including paying particular attention to the quality and quantity of one's diet.[17] Referencing Greek, Roman, Jewish and Islamic medical scholars, Burton also discussed the role of the other 'non-naturals' (air, exercise, sleeping and waking, excretion and passions/emotions) in triggering or forestalling melancholia, as well as how the condition tended be associated with old age, when 'the vivifying spirits diminished'.[18] Foreshadowing eugenic attempts to prevent mental health that emerged during the late nineteenth century and persisted well into the twentieth century, discussed by Erika Dyck and Despo Kritsotaki in this volume, Burton also suggested that parents susceptible to melancholia avoid procreating.[19] Above all, however, humoral medicine was about balance, whether that pertained to the six non-naturals or the humours (blood, phlegm, yellow bile and black bile) themselves, and balance has remained an important concept with respect to mental health both literally (work-life balance) or figuratively (having a balanced mind).[20]

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[16] World Health Organization, *Mental Health Action Plan: 2013–2020* (Geneva: World Health Organization, 2013), http://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=99E55C0C306D6A42ACACF6D3B21A7F1E?sequence=1, accessed 29 March 2018.

[17] Robert Burton, *Anatomy of Melancholy* (London: John Lichfield and James Short for Henry Cripps, 1621), 234–53.

[18] D.C.T. Maksimov, "Burton's *Anatomy of Melancholy*: Philosophically, Medically and Historically," Part II, *History of Psychiatry* 7 (1996), 352.

[19] Ibid.; Burton, *Anatomy of Melancholy*, 229–34.

[20] For more information about how the concept of balance has evolved, see the Wellcome Trust-funded project at the University of Exeter: "Lifestyle, Health and Disease: Changing Concepts of Balance in Modern Medicine," http://onbalance.exeter.ac.uk/, accessed 10

Just as balance continues to be considered an important concept with respect to mental health, controlling excesses in certain behaviours and habits were thought to be a preventive measure. During the early nineteenth century, for instance, physicians began to suspect masturbation or onania as a possible cause of mental disease.[21] Such concerns followed more general attacks on masturbation that emerged during the eighteen century, including *Onania*, purported to be written by the English surgeon John Marten in 1712 and *L' Onanisme* by the influential Swiss physician Samuel-Auguste Tissot (1728–1797) in 1758.[22] Tissot argued that, while masturbation could cause both bodily and mental ills, the latter were more serious and were caused in part by an increase in the flow of blood to the brain and exhaustion, but also by the 'shame and shocking remorse' which followed the act.[23] By 1826, Würzburg physician Joseph Häussler was claiming that madhouses were full of individuals who had indulged in masturbation, and that it could cause suicide, too.[24] Paradoxically, not satisfying the sexual instinct could also be dangerous, resulting in either nymphomania or 'melancholy of the religious kind'.[25]

April 2018. Such ideas are explored in a recent special issue of *Palgrave Communications* entitled 'On Balance: Lifestyle, Mental Health and Well-Being', which highlights not only the ancient roots of such ideas, but their ongoing relevance. Ali Haggett, "On Balance: Lifestyle, Mental Health and Wellbeing," *Palgrave Communications* (2016), https://www.nature.com/articles/palcomms201675; Peter Kinderman, "Knots and Black Holes: Why We're All Prone to Madness and What We Can Do About It," *Palgrave Communications* (2016), https://www.nature.com/articles/palcomms201674; Ayesha Nathoo, "Initiating Therapeutic Relaxation in Britain: A Twentieth-Century Strategy for Health and Wellbeing," *Palgrave Communications* (2016), https://www.nature.com/articles/palcomms201643; Matthew Smith, "A Fine Balance: Individualism, Society and the Prevention of Mental Illness in the United States, 1945–1968," *Palgrave Communications* (2016), https://www.nature.com/articles/palcomms201624, accessed 10 April 2018.

[21] Philipp Gutmann, "On the Way to a Scientia Sexualis: 'On the Relation of the Sexual System to the Psyche in General and to Cretinism in Particular' (1826) by Joseph Häussler," *History of Psychiatry* 17 (2006), 45–53.

[22] Thomas W. Laquer, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003); Philipp Gutmann, "'About Confusions of the Mind Due to Abnormal Conditions of the Sexual Organs' by Herman Joseph Löwenstein," *History of Psychiatry* 17 (2006): 107–33.

[23] Evan H. Hare, "Masturbatory Insanity: The History of an Idea," *Journal of Mental Science* 108 (1962): 1–25.

[24] Gutmann, "On the Way," 48.

[25] Ibid., 49.

The ‘women of harems’ and ‘many a nun’ were often victims of such conditions.[26] Masturbation continued to be identified as a cause for insanity throughout the nineteenth century (indeed, madness emerged as the primary danger associated with the act), with puberty being a particular period of concern.[27] Within asylums, attempts were made to limit the practice in order to halt the further deterioration of patients’ health. For instance, David Yellowlees (1835–1921), superintendent of Gartnavel Asylum in Glasgow, was so convinced that stopping his male patients from masturbation for a period of months would cure them that he devised a wire ring that was attached to the flaccid penis, making an erection virtually impossible.[28]

Although interest in masturbation as a cause for insanity faded during the twentieth century, due in part to the work done by sex researchers such as Havelock Ellis (1859–1939) and, later, Alfred Kinsey (1894–1956), concern about the role of alcohol in the onset of mental illness has persisted. Excessive alcohol consumption can kill in numerous ways, but concerns about the impact it could have on the mind began to be expressed during the eighteenth century. As Jonathan Reinarz and Rebecca Wynter describe, George Cheyne (1671–1743) warned that liquor could exacerbate the ‘English malady’ in 1733, during the height of the gin craze.[29] The British Quaker physician John Coakley Lettsom (1744–1815) would also caution in 1789 that excess alcohol consumption could cause ‘epilepsy, melancholy, madness and suicide’, also

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[26] Ibid.

[27] Allan Beveridge, “Madness in Victorian Edinburgh: A Study of Patients Admitted to the Royal Edinburgh Asylum Under Thomas Clouston, 1873–1908, Part II,” *History of Psychiatry* 6 (1995): 133–56; Laurent Sueur and Andrew Hodgkiss, “French Psychiatrists on the Causes of Madness, 1800–1870: An Ambiguous Attitude Before an Epistemological Obstacle,” *History of Psychiatry* 7 (1997): 267–75; Catharine Coleborne, “White Men and Weak Masculinity: Men in the Public Asylums in Victoria, Australia, and New Zealand, 1860s–1900s,” *History of Psychiatry* 25 (2014): 468–76.

[28] Jonathan Andrews, “A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry: Part 2,” *History of Psychiatry* 8 (1997): 333–60.

[29] Jessica Warner, *Craze: Gin and Debauchery in an Age of Reason* (London: Profile Books, 2003); Jonathan Reinarz and Rebecca Wynter, “The Spirit of Medicine: The Use of Alcohol in Nineteenth-Century Medical Practice,” in *Drink in the Eighteenth and Nineteenth Centuries*, eds. Susanne Schmid and Barbara Schmidt-Haberkamp (London: Pickering and Chatto, 2014), 131–33.

describing the symptoms of delirium tremens and alcohol psychosis.[30] This was despite the fact that, as Reinarz and Wynter demonstrate, alcohol was also used as a treatment for other mental afflictions.[31] Alcohol was also linked to degeneration and madness throughout Europe and during the early American republic.[32] Other intoxicants were also associated with madness both as a cause to be prevented and as a potential treatment. Cannabis, as with many currently illicit drugs, was used therapeutically for mental illness during the nineteenth century, only to be prohibited during the early twentieth century.[33] But while concerns about 'reefer madness' (made infamous in a 1936 American film) grew, some still thought it could be therapeutic for mental disorders, including depression.[34] Today, while marijuana can be used medically to treat many conditions (ranging from glaucoma to the side effects of chemotherapy) and has been legalised in some countries, there is also evidence that high-potency cannabis can cause schizophrenia.[35]

Concern about alcohol and other intoxicants was aligned with both ongoing research on brain pathology and its relationship to mental health and broader interests in public health and social progress during the late nineteenth and early twentieth centuries. These parallel developments often overlapped. Many asylums in both southern Europe (especially Italy) and the southern American states, for instance, contained poverty-stricken patients suffering from a form of pellagra, a vitamin

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[30] Reinarz and Wynter, "Spirit of Medicine," 131.

[31] Ibid., 132–33. Beer was also used as an incentive for patient labour in Victorian asylums. Niall McCrae, "The Beer Ration in Victorian Asylums," *History of Psychiatry* 15 (2004), 155–75.

[32] Patricia E. Prestwich, *Drink and the Politics of Social Reform* (Paolo Alto, CA: The Society for the Promotion of Science and Scholarship, 1988); Rafael Huertas and C.M. Winston, "Madness and Degeneration, II. Alcoholism and Degeneration," *History of Psychiatry* 4 (1993): 1–21; Patricia E. Prestwich, "Female Alcoholism in Paris, 1870–1920: The Response of Psychiatrists and of Families," *History of Psychiatry* 14 (2003): 321–36; Matthew Warner Osborn, *Rum Maniacs: Alcoholic Insanity in the Early American Republic* (Chicago: University of Chicago Press, 2014).

[33] James H. Mills, *Cannabis Britannica: Empire, Trade, and Prohibition, 1800–1928* (Oxford: Oxford University Press, 2003), 73–76.

[34] James H. Mills, *Cannabis Nation: Control and Consumption in Britain, 1928–2008* (Oxford: Oxford University Press, 2013), 30.

[35] R.M. Murray et al., "Cannabis-Associated Psychosis: Neural Substrate and Clinical Impact," *Neuropharmacology* 124 (2017): 89–104.

deficiency disease.[36] Pellagra, caused by lack of niacin, causes a range of physical symptoms but can also affect the brain, resulting in mental disturbance. It became more common in regions where traditional crops that contained niacin were replaced by corn, which does not contain the vitamin. While the precise cause of the 'pellagra psychosis' was biological, the fact that the poor, including African Americans in the southern states, were most vulnerable highlighted that the disorder also had profound social origins.[37] Similarly, although general paresis of the insane, caused by tertiary syphilis, affected a broader socioeconomic spectrum than did pellagra, it was similarly a biological cause infused with social and moral significance.[38]

More generally, however, concerns about public health and social progress increasingly dovetailed with those surrounding mental illness towards the close of the nineteenth century. As western societies industrialised and urbanised, alarms were raised about how such developments could affect mental health, causing disorders such as neurasthenia, which itself was rooted in new ideas about neurology.[39]

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[36] Mary Katherine Crabb, "An Epidemic of Pride: Pellagra and the Culture of the American South," *Anthropologica* 34 (1992): 89–103; José Lázaro, "The Concept of 'Delusion' in Spanish Psychiatry," *History of Psychiatry* 7 (1996): 124–25; Alan M. Kraut, *Goldberger's War: The Life and Work of a Public Health Crusader* (New York: Hill and Wang, 2003); Octavian Buda, "The Face of Madness in Romania: The Origin of Psychiatric Photography in Eastern Europe," *History of Psychiatry* 21 (2010): 286; David Gentilcore and Egidio Priani, "'San Servolo Lunatic!': Segregation and Integration in the Life Cycle of Pellagra Patients at Venice's Provincial Asylums (1842–1912)," in *Segregration and Integration in the History of the Hospital*, eds. Jane Stevens Crawshaw and Kathleen Vongsathorn (Rotterdam: Clio Medica, in press).

[37] Patrizia Guarnieri, "The History of Psychiatry in Italy," *History of Psychiatry* 2 (1992): 297–98.

[38] Gayle Davis, *The Cruel Madness of Love: Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam: Rodopi, 2008); Jennifer Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients, and Practices* (Basingstoke: Palgrave Macmillan, 2017).

[39] Such concern followed the warnings issued the previous century by George Cheyne in *The English Malady* (1733), and by Thomas Trotter in his 1807 text *View of the Nervous Temperament* and George Hayden in *An Essay on the Wear and Tear of Human Life* (1846). George Cheyne, *The English Malady; or, A Treatise of Nervous Disease* (London: C. Strahan, 1733); Thomas Trotter, *View of the Nervous Temperament* (Troy, NY: Wright, Goodenow and Stockwell, 1807); George T. Hayden, *An Essay on the Wear and Tear of Human Life* (Dublin: Fannin and Co., 1846). See also Roy Porter, "Nervousness, Eighteenth- and Nineteenth-Century Style: From Luxury to Labour," in *Cultures of Neurasthenia: From Beard to the First World War*, eds. Marijke Gijswijt-Hofstra and Roy Porter

Although it is still diagnosed in Asia, diagnoses of neurasthenia gradually declined following the First World War, and the disorder was finally dropped from the *DSM* in 1980 (it is still included in the WHO's *International Classification of Diseases*).[40] By the end of the nineteenth century, however, it was a popular diagnosis in many western countries, a 'disease of civilisation' that afflicted sensitive people (typically, white, middle-class and educated) who were not able to cope with the sensory overload that came with hectic city living.[41] Along with electrical 'cures' that aimed to replenish depleted nervous energy (such as electrical belts), sufferers and those at risk from neurasthenia could consider lifestyle changes to alleviate the symptoms or prevent the disorder altogether. Included amongst these interventions was not only the 'rest cure' described in the semi-autobiographical *The Yellow Wallpaper* (1892) but also suggestions to take up exercise and spend time in the great outdoors. As David Schuster describes in *Neurasthenic Nation*, concerns about neurasthenia provided momentum for the formation of the first American National Parks.[42]

Late nineteenth- and early twentieth-century psychiatric thought often portrayed heredity as the primary cause of mental illness. This interpretive framework problematised preventive efforts and fostered a pessimistic outlook on the prospects of cure and the functions of asylums, tendencies exacerbated by the rising numbers of chronic patients

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(Amsterdam: Rodopi, 2001), 31–49; Mark Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, MA: Harvard University Press, 2008); David Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort* (New Brunswick, NJ: Rutgers University Press, 2011).

[40] Pamela Yew Schwartz, "Why Is Neurasthenia Important in Asian Cultures?," *Western Journal of Medicine* 176 (2002): 257–58.

[41] For a good overview of neurasthenia, see Marijke Gijswijt-Hofstra and Roy Porter, eds., *Cultures of Neurasthenia: From Beard to the First World War* (Amsterdam: Rodopi, 2001). See also Brad Campbell, "The Making of 'American': Race and Nation in Neurasthenic Discourse," *History of Psychiatry* 18 (2007): 157–78; Tracy Loughram, "Hysteria and Neurasthenia in Pre-1914 British Medical Discourse and in Histories of Shell Shock," *History of Psychiatry* 19 (2008): 25–46; Schuster, *Neurasthenic Nation*; Jessica Slijkhuis and Harry Oosterhuis, "'Paralysed with Fear and Worry': Neurasthenia as a Gender-Specific Disease of Civilisation," *History of Psychiatry* 24 (2013): 79–93.

[42] Charlotte Perkins Gilman, *The Yellow Wallpaper* (London: Virago, 1981 [1893]); Schuster, *Neurasthenic Nation*.

which swelled the resident population of asylums,[43] and by Kraepelin's elaboration of dementia praecox, characterised predominantly as an incurable condition affecting younger patients which was marked by progressive deterioration.[44] Yet in practice, British psychiatrists argued that mental disorder arose from the interplay of social factors and hereditary predisposition. Writing in 1858, John Conolly (1794–1866) explained how asylums were filled by those from the 'poorer ranks of life', describing a patient whose 'sole inheritance was poverty and labour, and a brain predisposed to disease'. She was, he noted, 'industrious, and led a correct life', but 'to ensure food and clothing, and the shelter of a roof, it was necessary for her to work fourteen hours a day. No pleasures, no healthful exercise, were part of her lot'.[45]

Nineteenth-century psychiatrists, in other words, were cognisant of the role played by poverty and unemployment in bringing patients to the asylum, even if they did little in this era to tackle the issue. They did, however, advocate other social interventions which they claimed could lower the burden of mental illness. Thus, Henry Maudsley (1835–1918) sought to restrict women's access to education, cautioning that young women's intellectual work could only be accomplished at the expense of their reproductive health, and indeed the strength of the race more broadly.[46] Meanwhile, the Edinburgh psychiatrist Thomas Clouston (1840–1915) published a book for the public in which he outlined to his readers how diet, education and lifestyle could prevent the development

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[43] Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (Harmondsworth: Penguin Books, 1982).

[44] R.M. Ion and M.D. Beer, "The British Reaction to Dementia Praecox, 1893–1913: Part 1," *History of Psychiatry* 13 (2002): 285–304; R.M. Ion and M.D. Beer, "The British Reaction to Dementia Praecox, 1893–1913: Part 2," *History of Psychiatry* 13 (2002): 419–32. Paradoxically, Richard Noll has argued that the emergence of dementia praecox in American asylums gave superintendents hope that they could explain, if not treat, the symptoms endured by many of their patients. Kraepelin's emphasis on the biology of the disorder, in turn, helped to give American asylum physicians a certain degree of scientific respectability. Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Cambridge, MA: Harvard University Press, 2011).

[45] John Conolly, *Case Studies from the Physiognomy of Insanity* (1858), reprinted in Sander L. Gilman, ed., *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography* (New York: Brunnner/Mazel, 1976) 33, 38.

[46] Henry Maudsley, "Sex in Mind and in Education," *Fortnightly Review* 15, no. 88 (1874): 466–83.

of mental disorder.[47] Psychiatrists also increasingly looked beyond the walls of the asylum in their quest to prevent the onset of chronic mental illness, focussing on incipient or so-called borderline cases of mental illness. Reasoning that insanity was more easily cured if caught at its onset, the British Medical Association and Medico-Psychological Association unsuccessfully lobbied in 1896 for a revision to the lunacy legislation which would allow up to six months treatment without the need for certification and admittance to an asylum.[48]

Although prevention featured prominently in discussions of mental illness prior to the twentieth century, there was little coordinated effort on the part of governments or social reformers to take specific steps to prevent mental illness as had been the case in addressing public health issues such as clean water, sanitation or vaccination. Campaigners, such as Dorothea Dix (1802–1887), and groups, such as the Alleged Lunatics' Friends Society (founded in 1845), had begun to lobby for the rights of the mentally ill during the mid-nineteenth century, but their focus was on those already dealing with mental disorder, rather than those susceptible to it. This situation would change markedly during the twentieth century, beginning with the emergence of the mental hygiene movement and the child guidance movement.

Both the mental hygiene and child guidance movements would become influential throughout Europe and the Americas,[49] but initially

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[47] Thomas Clouston, *The Hygiene of the Mind* (London: Methuen & Co., 1906).

[48] "Incipient and Unconfirmed Insanity: Deputation to the Lord Chancellor," *Journal of Mental Science* 45 (1899): 415–17 (416); Vicky Long, *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870–1970* (Manchester: Manchester University Press, 2014), 100–4; Akinobu Takabayashi, "Surviving the Lunacy Act of 1890: English Psychiatrists and Professional Development During the Early Twentieth Century," *Medical History* 621, no. 2 (2017): 246–69.

[49] Deborah Thom, "Wishes, Anxieties, Play and Gestures: Child Guidance in Inter-war Britain," in *In the Name of the Child: Health and Welfare, 1880–1940*, ed. Roger Cooter (London: Routledge, 1992), 200–19; Mathew Thomson, "Mental Hygiene as an International Movement," in *International Health Organisations and Movements, 1918–1939*, ed. Paul Weindling (Cambridge: Cambridge University Press, 1995), 283–304; Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge, MA: Harvard University Press, 1999); Harry Oosterhuis, "Outpatient Psychiatry and Mental Health Care in the Twentieth Century," in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, eds. Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar, and Hugh Freeman (Amsterdam: Amsterdam University Press,

emerged in the United States as part of the Progressive Era reforms, which took place between 1870 and 1920.[50] In the US, mental hygiene was often associated with the National Committee for Mental Hygiene, which was founded in 1909 by former asylum patient, author and reformer Clifford Beers (1876–1943) and the pioneering Swiss-American psychiatrist Adolf Meyer (1866–1950).[51] Similarly, child guidance can be traced to the influential Juvenile Psychopathic Institute in Chicago, which was founded by psychiatrist and criminologist William Healy (1869–1963) in the same year.[52] Imbued by a combination of progressive social reform and Darwinian eugenics that may seem odd today, but existed in tandem for many decades, both movements concentrated on restoring the mentally ill to health and identifying and pushing for preventive strategies. Each combined a focus on the provision of prophylactic and therapeutic clinical services with an emphasis on lobbying government for policies aimed at the prevention of mental illness and the better treatment of the mentally ill.

The clinical approach of both the child guidance and mental hygiene movements was not only preventive, but also involved a multidisciplinary work where psychiatrists, paediatricians and other physicians collaborated with psychologists and psychiatric social workers, an approach that

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2005), 248–76; John Stewart, *Child Guidance in Britain, 1918–1955: The Dangerous Age of Childhood* (London: Pickering and Chatto, 2013); Jonathan Toms, *Mental Hygiene in Modern Britain* (Basingstoke: Palgrave Macmillan, 2013); Katarina Piuva, "Revisiting Mental Hygiene: Josef Lundal's Interpretation of Modern Psychiatry in Sweden at the Beginning of the Twentieth Century," *History of Psychiatry* 24 (2013): 34–45; Despo Kritsotaki, "Mental Hygiene and Child Guidance in Post-war Greece: The Case of the Centre for Mental Health and Research, 1956–1970," *Social History of Medicine* 27 (2014): 751–67.

[50] The historiography on the Progressive Era is vast and segues into many different avenues, but here are some references that relate closest to health and social reform. Ruth Clifford Engs, *The Progressive Era's Health Reform Movement: A Historical Dictionary* (Westport, CT: Praeger, 2003); James Marten, *Childhood and Child Welfare in the Progressive Era: A Brief History with Documents* (Boston: Bedford/St. Martin's, 2005); Michael McGerr, *A Fierce Discontent: The Rise and Fall of the Progressive Movement in America* (Oxford: Oxford University Press, 2005); Christopher McKnight Nichols and Nancy C. Unger, eds., *A Companion to the Gilded Age and Progressive Era* (Oxford: Wiley-Blackwell, 2017).

[51] Clifford Beers, *A Mind That Found Itself* (New York: Longmans, Green, 1908).

[52] Jones, *Taming the Troublesome Child*, Chapter 4.

would endure well after the Second World War.[53] Although there was some overlap between the disciplinary boundaries, the physicians in these tripartite units dispensed medical advice, while the psychologists provided clinical assessments, and the social workers worked with families—often in the community—to determine the environmental causes of disorder and take steps to prevent mental illness in vulnerable individuals. Psychiatric social workers emphasised the therapeutic aspects of their work, arguing that mothers suffering from their own unresolved issues often inadvertently caused children's problems through inadequate parenting. Resolution of the child's problems, in other words, could only be accomplished if mothers were treated by psychiatric social workers as patients in their own right. This concept widened the therapeutic lens from the individual patient to his or her family as a whole. Educating the public about mental hygiene and child guidance was also a vital component of such work. Depending on the country involved, funding for such activities could come from the public purse or charities, including the Commonwealth Fund of New York, which funded—amongst many other initiatives—the London Child Guidance Clinic and a mental hygiene centre at Yale University Medical School.[54] In England, the 1937 amalgamation of three of the four main mental health charities into the National Association for Mental Health served to strengthen and coordinate voluntary action in the promotion of mental health and prevention of mental illness.[55]

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[53] Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America* (Princeton, NJ: Princeton University Press, 1994); Joseph M. Gabriel, "Mass-Producing the Individual: Mary C. Jarrett, Elmer E. Southard, and the Industrial Origins of Psychiatric Social Work," *Bulletin for the History of Medicine* 79 (2005): 430–58; Chris Nottingham, "The Rise of the Insecure Professionals," *International Review of Social History* 52 (2007): 445–75; Vicky Long, "'Often There Is a Good Deal to Be Done, But Socially Rather Than Medically': The Psychiatric Social Worker as Social Therapist, 1945–70," *Medical History* 55 (2011): 223–39.

[54] Jonathan W. Engel, "Early Psychiatry at Yale: Milton C. Winternitz and the Founding of the Department of Psychiatry and Mental Hygiene," *Yale Journal of Biology and Medicine* 67 (1994): 33–47; Stewart, *Child Guidance*, 5.

[55] The three predecessor organisations were the Central Association for Mental Welfare, the National Council for Mental Hygiene and the Child Guidance Council. See Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (Abingdon: Routledge, 2006), 69–90.

In addition to the newly created child guidance clinics, other therapeutic spaces were established to curtail asylum admissions by providing care to incipient cases of mental distress. In Brighton, Dr. Helen Boyle (1869–1957) sought to circumvent the restrictions of the 1890 Lunacy Act which required patients to be certified as insane before they could secure asylum treatment, establishing a charitable hospital in 1905 for women suffering from nervous disorders.[56] Founded from a bequest in Henry Maudsley's will, the Maudsley Hospital opened in 1923 to provide in-patient and out-patient treatment for early cases of mental disorder, although it did not fully adhere to this brief in practice.[57] Legislative reform followed: the 1930 Mental Treatment Act aimed to increase the number of people seeking early treatment for mental health problems in England and Wales by providing for voluntary and out-patient treatment.

While the mental hygiene movement developed new sites of mental health care, another approach was to redesign existing spaces, such as factories and other workspaces, so as to enhance mental wellbeing in populations which had hitherto not been subject to psychiatric and psychological scrutiny. By the late nineteenth century, factories had come to epitomise all the undesirable by-products of the industrial revolution for many critics, undermining skilled labour, individual creativity and freedom in an environment that was as hazardous to psychological well-being as it was to physical health. Although this critique originated from the left, it resonated with employers seeking to boost output and was sanctioned by the British government during the First World War as a means of increasing munitions production. Vocational guidance sought to tackle the problem of the demotivated worker by identifying appropriate jobs for individuals' temperaments and aptitudes, but in practice, the rise in mechanisation and repetitive work tasks restricted this objective. Occupational health practitioners, industrial psychologists and industrial welfare supervisors, therefore, argued that industrial workspaces should be reconfigured into sites of health improvement which catered for workers' physiological needs but also addressed their

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[56] Louise Westwood, "Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890–1939," (DPhil diss., Sussex University, 1999); Louise Westwood, "A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899–1939," *Social History of Medicine* 14, no. 3 (2001): 439–57.

[57] Edgar Jones and Shahina Rahmen, "Framing Mental Illness, 1923–1939: The Maudsley Hospital and Its Patients," *Social History of Medicine* 21, no. 1 (2008): 107–25.

psychological well-being, compensating for unrewarding work tasks and helping to minimise the impact of neurotic illness on industrial outputs. Accordingly, managers were encouraged to improve lighting, heating and seating arrangements, and provide their workers with canteens, bathrooms, first aid facilities and a range of welfare and recreational provisions.[58]

Growing scrutiny of industry, in turn, prompted doctors to diagnose a large proportion of the industrial workforce with a psychological disorder. Public health investigator James L. Halliday (1897–1983), for example, argued that around a third of all industrial workers incapacitated from work were suffering from psychoneuroses, although four fifths of these cases were misdiagnosed with a physiological ailment.[59] Other studies suggested that a substantial number of those in work were battling with neuroses which had, in part, been triggered by excessive working hours and monotonous work. Industrial health researcher Russell Fraser, for example, claimed that 30% of the workers he surveyed suffered from some degree of neurosis.[60] Surveys such as this suggested a hidden burden of mental illness concealed within the population—one which posed a threat to national prosperity as much as to individual happiness.

The emphasis on prevention accelerated during and after the Second World War in response to domestic and military pressures. On the home front in Britain, the mass evacuation of children drew attention to children's psychological development and ways of protecting their mental health. Surveying of the impact of evacuation on children, psychologist Susan Isaacs (1885–1948) acknowledged that the strength of the family

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[58] Vicky Long, *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain, 1914–60* (Basingstoke: Palgrave Macmillan, 2011); Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Free Association Books, 1999), 55–119.

[59] James L. Halliday, "Psychoneurosis as a Cause of Incapacity Among Insured Persons: A Preliminary Inquiry," *British Medical Journal* 1, no. 3871 (March 1935): 99–102; Rhodri Hayward, "Enduring Emotions: James L. Halliday and the Invention of the Psychosocial," *Isis* 100, no. 4 (2009): 827–38; Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), 166–71.

[60] Russell Fraser, *The Incidence of Neurosis Among Factory Workers: Industrial Health Research Board Report No. 90* (London: Industrial Health Research Board, 1947); Long, *The Rise and Fall*, 136–43; Ali Haggett, *A History of Male Psychological Disorders in Britain, 1945–1980* (Basingstoke: Palgrave Macmillan, 2015), 57–81.

tie had not been fully taken into consideration. ‘It seems an extraordinary thing that we should have allowed so much neglect of human feeling and personal issues’, she observed.[61] Contributors to Isaacs’ survey included leading British psychiatric social worker Sybil Clement Brown (1899–1993) and the psychologist John Bowlby (1907–1990), so it is perhaps unsurprising that the survey helped create a climate in which Bowlby’s attachment theory—the idea that a child’s emotional development depended upon their bond with their primary caregiver—gained widespread acceptance, and that child guidance and psychiatric social work were subsequently embedded within the welfare state as part of a broader programme of post-war reconstruction.[62]

Eager to avoid the high levels of shell shock that had been experienced during the First World War, British military psychiatry invested in prevention during the Second World War, though the success of such initiatives has been debated by historians.[63] Efforts to provide therapy to large groups of armed forces personnel who displayed psychological and psychosomatic symptoms would, however, have a profound impact on post-war psychiatric practice. Pioneered at Northfield and Mill Hill hospitals, a number of psychiatrists developed this into the post-war therapeutic community model, which argued that all relationships within mental hospitals could be used to accomplish therapeutic goals.[64] Although the objective here was to transform inpatient care, it highlighted the role played by social environments and interpersonal relationships in promoting mental health.[65] For Maxwell Jones (1907–1990),

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[61] Susan Isaacs, ed., *The Cambridge Evacuation Survey: A Wartime Study in Social Welfare and Education* (London: Methuen & Co., 1941), 10.

[62] John Bowlby, *Maternal Care and Mental Health* (Geneva: World Health Organization, 1952); Stewart, *Child Guidance in Britain*, 107–43.

[63] Ben Shephard, “‘Pitiless Psychology’: The Role of Prevention in British Military Psychiatry in the Second World War,” *History of Psychiatry* 10 (1999): 491–524; Edgar Jones, K.C. Hyams, and Simon Wessely, “Screening for Vulnerability to Psychological Disorders in the Military: A Historical Survey,” *Journal of Medical Screening* 10 (2003): 40–46.

[64] Tom Harrison and David Clarke, “The Northfield Experiment,” *British Journal of Psychiatry* 160 (1992): 698–708; Stuart Whiteley, “The Evolution of the Therapeutic Community,” *Psychiatric Quarterly* 75 (2004): 233–48.

[65] In the UK, social psychiatry tended to be associated with a more socially-oriented approach to treatment (exemplified in therapeutic communities), rather than preventive psychiatry. One objective of British pioneers of social psychiatry, however, was to prevent relapse, and this was often referred to as tertiary prevention. Secondary prevention has

one wartime pioneer of the therapeutic community, the experience demonstrated psychiatrists' ability to prevent mental illness by intervening in people's family life, and social environment before individuals became incapacitated by their symptoms.[66]

In the US, the military demands of the War saw psychiatry reach unprecedented levels of authority and prestige. In order to prevent psychiatric casualties, the American military screened recruits for psychological fitness and ultimately rejected 12% on psychiatric grounds, six times the figure for the First World War.[67] Despite these measures, there were over one million psychiatric hospital admissions during the war. Regardless of the effectiveness of such screening, military psychiatrists, such as William C. Menninger (1899–1966) were confident that the lessons learned during the war could be applied to civilian populations.[68] Given that the war had emphasised the apparently massive scale of mental illness within American society, which was also reflected in a postwar asylum population of nearly half a million people, the prevention of mental illness became a priority for both psychiatrists and politicians.[69]

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tended to be identified with early identification and intervention. In this volume we focus mainly on primary prevention: identifying the causes of mental illness and taking steps to eliminate them.

[66] Maxwell Jones, *Social Psychiatry in Practice: The Idea of the Therapeutic Community* (London: Tavistock Publications, 1952).

[67] Hans Pols and Stephanie Oak, "War and Military Mental Health: The US Psychiatric Response in the Twentieth Century," *American Journal of Public Health* 97 (2007): 2132–42. As Naoko Wake has demonstrated, homosexuality was often the 'disorder' identified during the screening process, and men from minority backgrounds were more likely to be deemed to be mentally unstable. Naoko Wake, *Private Practices: Henry Stack Sullivan, the Science of Homosexuality, and American Liberalism* (New Brunswick, NJ: Rutgers University Press, 2011).

[68] Roy R. Grinker and John P. Spiegel, *Men Under Stress* (Philadelphia: Blakiston, 1945); William C. Menninger, *Psychiatry in a Troubled World: Yesterday's War and Today's Challenge* (New York: Macmillan, 1948); Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013).

[69] The emphasis on prevention is made all the more remarkable by the fact that the postwar period saw the proliferation of many recently developed treatments (ranging from electroshock therapy, insulin shock therapy and lobotomy to psychoanalysis) and the emergence of the first generation of anti-psychotic, anti-anxiety and anti-depressant medications. Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991).

Responding to this desire for preventive psychiatry was a relatively new approach to mental health: social psychiatry.

The term 'social psychiatry' was first used in Germany during the first decades of the twentieth century to describe an approach to psychiatry focussed on identifying the social causes of mental disorder and determining how to prevent them.[70] As Heinz-Peter Schmiedebach and Stefan Priebe note, however, there was a strong eugenic component to the term in Germany.[71] Georg Ilberg's (1862–1942) 1903 paper on the topic, for instance, stated that 60–70% of all cases of mental disease were heritable, so the 'first task of social psychiatry was to prevent intermarriage between healthy and mentally ill persons'.[72] By the time of the Third Reich, social psychiatry had 'amalgamated with racial hygiene and euthanasia came to be promoted as a therapeutic measure', resulting in approximately 200,000 deaths.[73]

Following—and influenced by—the Second World War, however, social psychiatry became associated with investigating and changing the environmental conditions that shaped mental health, rather than addressing hereditary factors.[74] Although social psychiatry gained the most traction in the United States where it influenced both the deinstitutionalisation and community mental health movements, it was influential in many other countries as well, with the *International Journal of Social Psychiatry* and *Social Psychiatry* (along with more

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[70] Heinz-Peter Schmiedebach and Stefan Priebe, "Social Psychiatry in Germany in the Twentieth Century: Ideas and Models," *Medical History* 48 (2004): 449–72.

[71] Ibid., 451.

[72] The second and third tasks for social psychiatry were geared towards reducing rates of syphilis and alcoholism, which have been discussed above. Ibid., 452; Georg Ilberg, "Soziale Psychiatrie," *Monatsschrift Soziale Medizin* 1 (1903): 321–29, 393–98.

[73] Michael Burleigh, *Death and Deliverance: 'Euthanasia' in Germany c. 1900–1945* (Cambridge: Cambridge University Press, 1994); Paul J. Weindling, *Epidemics and Genocide in Eastern Europe 1890–1945* (Oxford: Oxford University Press, 2000); Rael D. Strous, "Psychiatry During the Nazi Era: Ethical Lessons for the Modern Professional," *Annals of General Psychiatry* 6 (2007), https://annals-general-psychiatry.biomedcentral.com/articles/10.1186/1744-859X-6-8, accessed 30 April 2018.

[74] Social psychiatry has been defined differently in various parts of the world: see World Health Organization, *Prevention and Promotion in Mental Health* (Geneva: World Health Organization, 2002), http://www.who.int/mental_health/media/en/545.pdf, accessed 1 May 2018; Jung-Ah Min, Chang-Uk Lee, and Chul Lee, "Mental Health Promotion and Illness Prevention: A Challenge for Psychiatrists," *Psychiatric Investigation* 10 (2013): 307–16.

general psychiatric journals) being the main outlets for research.[75] A ‘preventive psychiatry’, social psychiatry was also highly interdisciplinary, as social psychiatrists worked collaboratively with a range of social scientists (typically sociologists, anthropologists and psychologists) to carry out epidemiological studies.[76] Among the most influential of the studies that emerged were *Mental Disorder in Urban Areas* (1939) by Chicago School sociologists Robert E.L. Faris (1907–1998) and H. Warren Dunham (1906–1985); *Social Class and Mental Illness* (1958) by psychiatrist–sociologist team Frederick Redlich (1910–2004) and August B. Hollingshead (1907–1980); *Mental Health in the Metropolis* by a multidisciplinary team including social scientists Leo Srole (1909–1993) and Marvin Opler (1914–1981); and the still-running Stirling County Studies (in Nova Scotia, Canada), which was led by psychiatrist/sociologist Alexander H. Leighton (1908–2007) and is now led by his widow, Jane Murphy Leighton (b. 1929).[77]

[75] Liam Clarke, “Joshua Bierer: Striving for Power,” *History of Psychiatry* 8 (1997): 319–32; Schmiedebach and Priebe, “Social Psychiatry in Germany”; Einar Kringlen, “A History of Norwegian Psychiatry,” *History of Psychiatry* 15 (2004): 259–83; André I. Wierdsma, “Emergency Compulsory Admissions in the Netherlands: Fluctuating Patterns in Rotterdam, 1929–2005,” *History of Psychiatry* 20 (2009): 199–214; Nicolas Henckes, “Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis,” *History of Psychiatry* 22 (2011): 164–81; Harry Yi-Jiu Wu, “World Citizenship and the Emergence of the Social Psychiatry Project of the World Health Organization, 1948–c.1965,” *History of Psychiatry* 26 (2015): 166–81; Despo Kritsotaki, Vicky Long, and Matthew Smith, “Introduction: Deinstitutionalisation and the Pathways of Post-war Psychiatry in the Western World,” in *Deinstitutionalisation and After: Post-war Psychiatry in the Western World*, eds. Despo Kritsotaki, Vicky Long, and Matthew Smith (Basingstoke: Palgrave, 2016), 1–36; Christof Beyer, “‘Islands of Reform’: Early Transformation of the Mental Health Service in Lower Saxony, Germany in the 1960s,” in *Deinstitutionalisation and After*, eds. Kritsotaki, Long, and Smith, 99–114; Katariina Parhi and Petteri Pietikainen, “Socialising the Anti-social: Psychopathy, Psychiatry and Social Engineering in Finland, 1945–1968,” *Social History of Medicine* 30 (2017): 637–60; Mat Savelli, “Beyond Ideological Platitudes: Socialism and Psychiatry in Eastern Europe,” *Palgrave Communications* 4 (2018), https://www.nature.com/articles/s41599-018-0100-1, accessed 1 May 2018; Despo Kritsotaki, “From ‘Social Aid’ to ‘Social Psychiatry’: Mental Health and Social Welfare in Post-war Greece (1950s–1960s),” *Palgrave Communications* 4 (2018), https://www.nature.com/articles/s41599-018-0064-1, accessed 1 May 2018.

[76] Leonard J. Duhl, “Psychiatry in the Community,” *International Journal of Social Psychiatry* 1 (1955): 42–47.

[77] Robert E.L. Faris and H. Warren Dunham, *Mental Disorder in Urban Areas* (Chicago: University of Chicago Press, 1939); August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness: A Community Study* (New York: Wiley, 1958); Alexander

These studies and others tended to emphasise the role of social factors, including poverty, social isolation, class tensions and various aspects of the urban environment, as being important considerations in the epidemiology of mental illness.[78] While their authors tended not to delve too deeply into the political ramifications of such theories or argued that more research needed to be done before policy decisions could be made, there were exceptions to this reticence.[79] The final reports of the Joint Commission on Mental Health and Illness (1961) and the Joint Commission on the Mental Health of Children (1969), for instance, detailed specific measures to tackle poverty and social isolation.[80] One of the top recommendations of the latter Commission in their *Crisis in Child Mental Health: Challenge for the 1970s* was a universal basic income to mitigate the risks to mental health associated with extreme poverty.[81]

More generally, social psychiatry's emphasis on prevention nevertheless accorded with the progressive politics of the Kennedy and Johnson administrations in the US.[82] In a 1963 speech to Congress, John F. Kennedy (1917–1963) argued that the best way to deal with the financial and emotional burden of mental illness was prevention and, specifically, addressing 'the harsh environmental conditions' believed to cause it.[83]

H. Leighton, *My Name Is Legion: Foundations for a Theory of Man in Relation to Culture* (New York: Basic Books, 1959); Leo Srole et al., *Mental Health in the Metropolis: The Midtown Manhattan Study, Volume 1* (New York: McGraw Hill, 1962).

[78] Smith, "A Fine Balance"; Edmund Ramsden and Matthew Smith, "Remembering the West End: Social Science, Mental Health and the American Urban Environment, 1939–1968," *Urban History* 45 (2018): 128–49.

[79] Lawrence K. Frank, *Society as Patient: Essays on Culture and Personality* (New Brunswick, NJ: Rutgers University Press, 1950); Matthew Dumont, *The Absurd Healer: Perspectives of a Community Psychiatrist* (New York: Science House, 1968).

[80] Joint Commission on Mental Health and Illness, *Action for Mental Health* (New York: Basic Books, 1961); Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970s* (New York: Harper and Row, 1969).

[81] Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health.*

[82] Grob, *From Asylum to Community*; Dan Blazer, *The Age of Melancholy: Major Depression and Its Social Origins* (New York: Routledge, 2005); Michael Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948–1980* (Chicago: University of Chicago Press, 2011).

[83] John F. Kennedy, "Special Message to Congress on Mental Illness and Mental Retardation" (5 February 1963), http://www.presidency.ucsb.edu/ws/?pid=9546, accessed 1 May 2018.

Three weeks before Kennedy's assassination in November 1963, the Community Mental Health Centers Construction Act was passed, paving the way for hundreds of community mental health centres (CMHCs) to be built across the US. After Kennedy's death, an amendment was passed providing funding for the staffing of these centres. As the founding director of the National Institute of Mental Health, Robert H. Felix (1904–1990) stressed, such centres were not only meant to treat the thousands of people currently residing in asylums, but also—and more importantly—they were to be heavily involved in prevention, including what Felix described (but did not define) as 'social action'.[84] Felix urged that psychiatrists, along with the psychiatric social workers, psychologists and others working in CMHCs, become more 'civically active'.[85]

By the 1970s and 1980s, however, most CMHCs were struggling financially, and prevention was dropping in their list of priorities.[86] Similarly, social psychiatry was losing its intellectual and political influence. Within psychiatry, biological (especially genetic) explanations for mental illness were becoming more popular, alongside pharmaceutical treatments.[87] Social psychiatry itself became somewhat fragmented. While some radical psychiatrists continued to press for political change, including improved civil rights for the mentally ill, others gravitated towards transcultural psychiatry and still others simply moved from the field altogether.[88] It could also be argued that white, middle class, male social psychiatrists shied away from investigating certain factors, while over-emphasising others. What a twenty-first century observer might describe as child abuse (sexual, physical, emotional) can be found in the psychoanalytical literature of the period, but such cases do not tend to

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[84] Robert H. Felix quoted in E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (Oxford: Oxford University Press, 2014), 47.

[85] Robert H. Felix, "The Image of the Psychiatrist: Past, Present, and Future," *American Journal of Psychiatry* 121 (1964): 318–22.

[86] Marvin Karno and Donald A. Schwartz, *Community Mental Health: Reflections and Explorations* (New York: Wiley, 1974).

[87] David Healy, *The Creation of Psychopharmacology* (Cambridge, MA: Harvard University Press, 2002).

[88] Lucas Richert, "'Therapy Means Change, Not Peanut Butter': American Radical Psychiatry, 1968–1975," *Social History of Medicine* 27 (2013): 104–21.

emerge in the contemporaneous epidemiological studies.[89] Similarly, although race and racism loomed (and continues to loom) large in some discussions about the epidemiology of mental illness, its role was not as predominant as one might have expected.[90] Faris and Dunham's study of schizophrenia in Chicago during the 1930s, for instance, found that poverty and social disorganisation were much more significant predictors of mental disorder than race.[91] Neither Hollingshead and Redlich's survey of class and mental illness in New Haven, Connecticut, nor the Midtown Manhattan Study addressed race to any significant extent. In the former case, New Haven during the 1950s had yet to experience the migration of African Americans that would follow in subsequent decades; in the latter case, the Midtown investigators simply made a decision not to include African American or Puerto Rican New Yorkers in their influential survey.

Politically, the progressive politics that ushered in the Great Society welfare policies during the 1960s were swept aside amidst economic turmoil during the 1970s and an eventual turn to the right in the US, the UK and many other countries during the 1980s. The emphasis on prevention that had been central to thinking about mental health for much of the twentieth century and, indeed, previous centuries, was marginalised in the search for better and more profitable drug therapies. While there have been recent efforts by the World Health Organization (through their Social Determinants of Health agenda) and mental health charities to put prevention at the forefront of not only mental health research, but also public policy, politicians and political parties have been reluctant to take direct action. In Britain, statutory and voluntary organisations have increasingly emphasised the importance of prevention since the turn of the twenty-first century but calls to focus 'more attention "upstream" into promotion, education, prevention and early

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[89] Given the litany of child sexual abuse scandals that have emerged since 2000 and their connections with mental health (for instance, as outlined in the Adverse Childhood Experiences literature), a historical examination of how psychoanalysts perceived and dealt with such abuse during the twentieth century should be made a priority for historians.

[90] Kimberlie Dean and Robin Murray, "Environmental Risk Factors in Schizophrenia," *Dialogues in Clinical Neuroscience* 7 (2005): 69–80; Mical Raz, *What's Wrong with the Poor? Psychiatry, Race, and the War on Poverty* (Chapel Hill: North Carolina University Press, 2013); Dennis Doyle, *Psychiatry and Racial Liberalism in Harlem, 1936–1968* (Rochester: Rochester University Press, 2016).

[91] Faris and Dunham, *Mental Disorder*.

intervention'[92] have made little headway given the government's failure to redress the gap in funding allocated to mental health providers versus other NHS health care providers.[93] Moreover, there is very little awareness amongst policy makers or mental health professionals of the rich history of preventive approaches to mental health.[94] It is quite possible that those eager to prevent mental illness today and in future neglect to learn the lessons of past attempts.

Although it would be easy to blame policy makers and mental health professionals for not paying close enough attention to their history, historians of psychiatry and mental health should also shoulder part of the blame for this lack of awareness. Despite the fact that the history of psychiatry and mental health is arguably the most popular topic within the history of medicine, boasting its own journal and dedicated book series, the history of preventing mental illness has simply not attracted as much attention from historians as it might have. Prevention tends to get mentioned in passing, rather than being the primary basis of inquiry, and when it is addressed more thoroughly, it tends to be dismissed as a chimera.[95] It is possible that this is the case because most histories of psychiatry and mental health have been written during a period when the idea of preventing mental illness was waning or simply overlooked.

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[92] The Future Vision Coalition, *A Future Vision for Mental Health* (2009), 15, http://www.nhsconfed.org/-media/Confederation/Files/Publications/Documents/Future_vision_for_mental_health_FINAL.pdf, accessed 4 May 2018. The 'coalition' here comprised of the Association of Directors of Adult Social Services; the Association of Directors of Children's Services; the Local Government Association; the Mental Health Foundation; the Mental Health Providers Forum; Mind; NHS Confederation—Mental Health Network; Rethink Mental Illness; the Royal College of Psychiatrists; the Sainsbury Centre for Mental Health and Together.

[93] Helen Gilburt, "Funding and Staffing of NHS Mental Health Providers: Still Waiting for Parity," *The King's Fund* (January 2018), https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers, accessed 19 May 2018.

[94] This lack of awareness is reflected both in the lack of references in more recent literature on preventive mental health to the history of such approaches and in the experiences of one of the authors (Smith) in presenting to a wide range of audiences about the history of social psychiatry and preventive psychiatry more generally. In 2015, for instance, Smith gave a talk to the New York Department of Health and Mental Hygiene about the Midtown Manhattan Study. None of the large audience, including those who had begun their careers in the 1970s, were aware of this pioneering study or its implications. See also Matthew Smith, "Mixing with Medics," *Social History of Medicine* 24 (2011): 142–50.

[95] See Grob, *From Asylum to Community*; Torrey, *American Psychosis.*

The ultimate objective of this volume is to change this state of affairs, partly to emphasise a theme in the relevant historiography that has been overlooked, but also—and more importantly, perhaps—to stoke and inform debate and conversation about how to prevent mental illness and improve mental health in the years to come.

Contents

This volume has its origins in a conference and witness seminar held at the University of Strathclyde's Ross Priory, on the bonny banks of Loch Lomond, in 2016. The two-day event was generously funded by the Arts and Humanities Research Council (UK) and the Wellcome Trust, and began with a witness seminar featuring three American and three British psychiatrists with experience of social psychiatry, community mental health care and psychiatric epidemiology. Following the witness seminar, a series of historical papers were given on the topic of 'Preventing Mental Illness: Past, Present and Future', and it is from this conference that the majority of the chapters in this volume derive.

The first three chapters of *Preventing Mental Illness* converge upon the idea that the foundations of mental health are set early in life, and examine the different ideas and practices of mental illness, violence and crime prevention for children, adolescents and youths in twentieth-century America. Focusing on the 1940s and 1950s, Dennis Doyle investigates the ways in which psychiatrists, within the framework of preventive psychiatry and mental hygiene, linked comic books with the prevention of emotional and behavioural troubles, in particular violence. Based on different understandings of the human imagination, comic book opponents argued that comic books caused misbehaviour, violence and delinquency and that they should not be sold to minors, while comic book defenders contended that comic books did not cause but actually helped prevent juvenile delinquency. This debate on comic books highlights that mental health experts were asserting their responsibility to educate and protect the public in this new era of popular culture and mass media, and not only prevent mental illness but also various social ills.

The increasing popularity of comics was part of the flourishing youth culture and expanding youth market after the Second Wold War. But, as children and adolescents were acquiring new social roles and cultural value, adults became increasingly worried about their mental health and demeanour. Against this background adolescent medicine was established as a distinct medical/paediatric field and, as Iain Ferguson argues, acne was constructed as a psychological and social problem of adolescence. In post-war America, acne came to be seen not only as a cause and effect of emotional turmoil, mainly stress, experienced by teenagers with busy lives and problematic family and social relationships, but also as a threat to adolescents' present and future social position, as well to the social order. Therefore, its early and efficient treatment could not only prevent facial disfigurement, but also mental illness, social maladjustment, antisocial behaviour, sexual promiscuity, delinquency and even social disorder and racial unrest. With all this at stake, professionals, adolescents and parents were willing to try a variety of treatments, from sedatives and tranquilisers to hypnosis and surgery, even if some of these methods proved dangerous.

Looking more closely at juvenile delinquency, Erin J. Lux shows how the changing social roles of children and adolescents, as well as the effects of the Second World War—mainly the disruption of families and 'normal' life—and the challenges of the Cold War, raised anxiety about youths and motivated the reform of the juvenile justice system in the USA. Between the 1940s and the 1960s, many states adopted a new preventive and rehabilitative model, with longer treatment-oriented sentences and the engagement of various agents: the police, social and health services, and increasingly psychiatry. The new model was soon challenged, however, not only because of a lack of supporting research and evidence, but also because of the long sentences and extensive interference into the lives of children who had committed no crimes. This was deemed as unconstitutional by the late 1960s, when ideas about individual rights had changed dramatically. And, while the expansion of penal institutions to meet the increased incarceration needs was initially portrayed as a progressive and positive step, the massive size and brutality of these institutions were eventually condemned.

While not concentrating on childhood and adolescence, the following chapter demonstrates that prevention was inextricably linked with safeguarding the mental health of young people outside the US too. Despo Kritsotaki argues that models of prevention in twentieth-century Greece continuously focussed on the protection of childhood, as well as the education of the public. Alongside these continuities, discourses on prevention became more systematic and diverse in the second half of the twentieth century, and their orientation shifted in the 1940s from physical to psychosocial issues, before biological/genetic approaches resurfaced in the 1970s. The chapter analyses these trends within the context of Greek social and political conditions, and developments of the mental health field. However, it interprets the restricted practical impact of prevention discourses as indicative of the difficulties and shortcomings of prevention policies beyond Greece.

The impact of social psychiatry on prevention, underlined by Kritsotaki for Greece, is investigated in depth by Mat Savelli for Yugoslavia. In the early post-war period, the new Communist state and the medical profession envisioned a reformed Yugoslav society and a socialist health-care system, which would prioritise prevention. Necessitated by the material and political conditions of the time, this approach continued interwar trends but was fully developed in the 1960s and 1970s by psychiatrists who had studied in Britain, France, and the United States. They drew upon British and West European psychiatric thought, especially social psychiatry, and argued that mental illness could be prevented only if relationships within the family, the workplace, and broader society were transformed, and if the whole of society became engaged to the improvement of people's health. The chapter illustrates these ideas by focusing on three psychiatric fields, addiction, suicidology and military psychiatry, and closes in the 1990s, when the collapse of Yugoslavia and the brutal war invalidated the optimistic vision of psychiatry as able to prevent mental illness through social change.

Suicide prevention forms the subject of the next chapter, but in a completely different geographical and temporal frame: Finland from the 1860s to the 2010s. Suicide has been connected to mental illness at least since the nineteenth century, either as one of its forms or symptoms, but, as Mikko Myllykangas shows, it has also been understood as a multifaceted phenomenon, the prevention of which has been a central concern among scientists and policymakers. Myllykangas highlights shifting patterns of biological, social and psychodynamic models of suicide research, underlining the enduring connection between prevention practices and scientific discourses of suicide aetiology. Prevention strategies attempted throughout this period included social and economic improvements, anti-alcoholism campaigns, public health initiatives and education, and anti-depression medication, and sought to tackle a range of perceived causes, such as individual mental illness and genetics, national psychological and physical characteristics, or social factors, such as urbanisation, industrialisation and poverty. The chapter argues for a more comprehensive model of suicide prevention, which will meaningfully combine socially oriented, neuropsychological and neurochemical research.

Moving from self-harm to interpersonal violence, Matthew Gambino researches the origins of risk management in the USA during the 1960s and 1970s, focusing on the work of psychologist John Monahan, who argued that mental health professionals could and should make specific forms of violence prediction. Aware of anti-psychiatry and the social movements of the time, he understood that violence prediction might turn mental health professions into agents of social control, but concluded that it was not possible for clinicians to completely disengage from broader social welfare matters. His work was in line with broader trends—risk management became central in medical practice during the second part of the twentieth century—but also foresaw the emergence of risk assessment as a social management mechanism in neoliberal 'risk societies'. Today, the issue of whether violence can be predicted remains unresolved, and mental health professionals are still sceptical about their role in risk management. However, the latter has become a standard task of mental health practitioners, sometimes at the expense of therapeutic work, and, with deinstitutionalisation and the increase of patients living in the community, it has expanded psychiatry's social control functions.

The social roles of mental health professionals are further explored in the next two chapters. Lucas Richert and Matthew DeCloedt stress that the radical psychiatry movement in late 1960s and 1970s America demanded radical political and social change, and challenged the mental health-care reform that was inspired by social and preventive psychiatry. For radical psychiatrists, community-based psychiatry could not prevent mental illness, as it aimed not at social change but at social peace, and did not empower patients, but continued to oppress them. But patients did not stay passive: during the same period, a dynamic ex-patient movement emerged, which in some cases excluded professionals, even radical psychiatrists. For these patient activists, one way to prevent mental illness was to prevent its diagnosis and treatment by professionals. Richert and DeCloedt analyse the relationships between patient activism and radical psychiatry, and highlight the latter's multifaceted ideology, which led early on to internal divisions and unintended consequences.

Staying in North America, but going back to the 1950s and 1960s, Edmund Ramsden provides an insight into a different endeavour to renew psychiatric practice and broaden the social scope of psychiatry.

He focuses on the Architectural Study Project (ASP), which began in 1953, as distress over mental hospital facilities grew and the need of reform became urgent. The ASP brought together psychiatrists, architects and behavioural scientists, and generated new ideas of prevention and treatment of mental illness away from long-term custodial care. In addition, the research on the relations between the built environment and patient behaviour was applicable to other architectural fields; thus, the mental hospital served as a 'laboratory' where concepts and methods were developed to understand spatial behaviour, leading to the emergence of the interdisciplinary field of environmental psychology in the 1960s. The principles established in the context of the mental hospital were incorporated into diverse urban spaces, such as general hospitals, family apartments, schools, factories and public buildings, in order to sustain communal living, build cohesive communities, promote psychosocial well-being and prevent crime and mental illness.

In the penultimate chapter of the volume, Erika Dyck reconsiders the recent history of eugenics and sterilisation in Canada, in order to approach the precarious balance between individual freedom and protection in mental illness prevention from a different perspective. She studies how debates on the sterilisation of people with psychiatric or intellectual disabilities during the 1970s were affected by the changing social and legal context, notably the legalisation of contraception and abortion, and growing deinstitutionalisation. These developments fuelled concerns over the sexual life of individuals with intellectual disabilities living in the community, while human and patients' rights movements defended the liberty and autonomy of these individuals. Therefore, sterilisation, which was directed more at women than men, was reconfigured as a humanitarian policy that could ensure personal hygiene and (sexual) freedom. In other words, in the post-war period, when older eugenic theories on heredity were discredited scientifically, and individual rights were given priority over the concerns of the state, eugenics did not become extinct but transformed into 'newgenics'. This adopted the language of rights, moved from mental to personal hygiene, and prioritised a socio-economic rather than a hereditary approach to prevention.

Sterilisation was not the only form of prevention that targeted women more often than men. Turning to post-war Britain, the final chapter of the volume highlights that, while health and wellbeing information became increasingly available since the 1960s, mental health campaigns were usually aimed at women and information on male mental health was scarce. Ali Haggett argues that this reflected—and reinforced—prevailing gendered assumptions: women were thought of as more prone to mental illness, responsible for the health of their families, and more likely to seek mental health information, while the stereotype of the 'strong, silent man', who did not need and/or did not seek medical advice, did not show his emotions and/or did not suffer psychologically persisted. Even the feminist movement, in its own way, added to the neglect of men's psychological health, by bringing to the fore the medical, legal and social disadvantages and unmet needs of women. Today in Britain, Haggett concludes, gendered assumptions on mental vulnerability and the stigma of mental illness endure and hinder prevention. Therefore, along with the challenges faced by women, we are encouraged to understand and address the ways in which men are biologically and culturally vulnerable to mental ill-health.

Conclusion

It is not by mistake that the subtitle of this volume reads *Past, Present and Future*. Throughout the conference that spurred this book, there was copious discussion about how current and future attempts to prevent mental illness and improve mental health should be informed by those of the past. While some of these lessons tell us what we perhaps ought to do, it is worth emphasising that many of them focus on what we should avoid. During the final summary session that concluded the conference, the collected group of historians and mental health professionals concentrated on what the future steps to prevent mental illness should be. Although there was no unanimity in terms of what should be done, we thought it worth mentioning some of the recommendations. Overall, the suggestions our contributors had can be divided into three broad categories: (1) demystifying and, perhaps, de-medicalising mental illness by changing the way we think and talk about it; (2) getting serious about the socioeconomic determinants of mental illness; and (3) investing in more research focussed on the prevention of mental illness.

The first category of recommendations illuminates a strange tension that often emerges when historians discuss mental health and illness. On the one hand, historians are keen to emphasise the historical and cultural contingency of mental illness, that what is considered 'mad' in one time and place may well be considered 'normal' in another. On the other hand, there is an increasing desire amongst historians, not least those who participated in the ‘Preventing Mental Illness’ conference, to try to use historical insights to improve the ways society deals with mental illness. One way to resolve this apparent—and possibly false—dichotomy, according to our conference participants, is to demystify and, in turn, destigmatise mental illness. A strategy frequently adopted in anti-stigma campaigns is to emphasise how common mental health problems are. As Frank Reilly argues in the foreword to this volume, for example, mental health problems affect all of us in one way or another at different points in our lives. Acknowledging that some kinds of ‘madness’ may in fact be absolutely ‘normal’ (for instance, the depression that follows bereavement, the stress and anxiety that accompanies parenthood or the dementia that comes with advanced age) may make us less likely to see those with more pronounced mental health problems as categorically different from the rest of us. There is no consensus that this approach is necessarily effective, however. Having researched health care professionals’ efforts to educate the public about mental illness in Britain over a hundred year period, one member of the editorial team (Long) concludes that many people find this argument unconvincing because they recognise that experiences currently lumped together under the heading mental health problems diverge significantly. Such campaigns may succeed in making acute, short-term and less severe mental health problems more social acceptable, while doing little to unpick the stigma of enduring and severe mental illnesses. Long argues that structural discrimination, rather than public ignorance, underpins the stigmatisation of mental illness. She suggests that campaigns led by grassroots groups which depict the experiences of individuals who live with serious mental health issues and highlight how their lives are made more difficult by forms of structural discrimination that stem in part from government policies would have more impact.[96]

Indeed, engaging with and supporting service user and survivor-led grassroots groups could help further efforts to adopt a more rights-based approach to mental health, for these organisations have, since their inception in the 1970s, championed this agenda.[97] One of our

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[96] Long, *Destigmatising Mental Illness?*

[97] Mark Gallagher, “From Mental Patient to Service User: Deinstitutionalisation and the Emergence of the Mental Health Service User Movement in Scotland, 1971–2006,” (Ph.D. diss., Glasgow University, 2017); Crossley, *Contesting Psychiatry*; Jan Wallcraft, Jim Read, and Angela Sweeney, *On Our Own Terms: Users and Survivors of Mental Health Services Working Together for Change* (London: Sainsbury Centre for Mental Health, 2003).

witness seminar participants, for instance, observed that in the last fifty years enormous strides (if also some backwards steps) have been made in establishing and safeguarding the rights of women, ethnic and racial minorities, LGBT people and people with certain types of disabilities. Can we really say this about the mentally ill when we consider the high percentages of homeless and imprisoned people who have diagnosed mental disorders? If we adopted a more rights-based approach to mental health and worked towards eliminating the barriers the mentally ill face with respect to employment, access to health care and a basic standard of living, we might be less likely to treat them as the 'other',[98] particularly if service users are meaningfully involved themselves in this agenda. Such thinking can reinforce some of the messages behind the neurodiversity movement, which encourages society to find ways to adapt to people who experience and interact with the world differently, rather than expecting the 'neuroatypical' to do all the adapting. Indeed, there may be some merit in adopting the social disability model, which contends that people are disabled by society's failure to adjust to their needs, as a means of improving access and rights for people who experience mental health problems.[99] Such an approach would, however, need to be tailored to the distinctive needs experienced by people with mental health problems, acknowledging that many service users do not view themselves as having a hidden physical impairment.[100]

Given that stereotypes of mental health and illness are often set at a young age, our participants also believed that developing 'mental health literacy' early in life was essential to changing perceptions.[101] Reflecting on the principles of the early twentieth century child guidance and mental hygiene movements, some of our participants suggested that

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[98] Stephanie Knaack, Ed Mantler, and Andrew Szeto, "Mental Illness-Related Stigma in Healthcare: Barriers to Access and Care and Evidence-Based Solutions," *Healthcare Management Forum* 30 (2017), 111–16.

[99] Liz Sayce, *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion* (Basingstoke: Macmillan, 2000).

[100] Anne Plumb, "…Distress or Disability?," in *Distress or Disability? Proceedings of a Symposium Held at Lancaster University, 15–16 November* 2011, eds. Jill Anderson, Bob Sapey, and Helen Spandler (Bowland North: Lancaster University, 2012), 3–12.

[101] Alan Mcluckie, Stan Kutcher, Yifeng Wei, and Cynthia Weaver, "Sustained Improvements in Students' Mental Health Literacy with Use of a Mental Health Curriculum in Canadian Schools," *BMC Psychiatry* 14 (2014), https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-014-0379-4, accessed 20 May 2018.

improving children's understandings of mental health might both reduce stigma and highlight the wide range of risk factors connected to poor mental health. If children are willing and able to articulate when they are struggling with stress and anxiety, not only does it becomes easier to offer them support, but it also improves our understanding of what contributes to good or bad mental health. Recent research on Adverse Childhood Experiences (ACEs), for example, has emphasised the role of stressors (including domestic violence, abuse, parental abandonment, neglect and growing up with parents who spend time in prison or struggle with addiction issues) in the development of mental health problems in later life.[102] Children exposed to such factors are also connected to other chronic diseases (such as heart disease and type 2 diabetes), and are more likely to be violent, to abuse drugs and alcohol and to end up in prison. Although focussing on reducing ACEs is undoubtedly an important approach to reducing mental illness, improving the mental health literacy of children may also lead to new and more nuanced insights about what factors influence mental health and how they may change over time. Does severe acne affect the mental health of young people as severely as the researchers studied by Iain Ferguson suggested? Perhaps comic books are no longer thought to lead children inextricably to the asylum but are today's concerns about violent video games or social media similarly misguided? Or are we right to be concerned? Might there be other stressors that do not fall into the ACEs framework that should be considered? Ensuring that conversations with children about mental health are not merely unidirectional will help to build a more sophisticated understanding of the factors that improve and damage mental health.

As many researchers have stressed, dealing with ACEs is more than a public health issue; it is also a political issue,[103] which leads to the second category of recommendations made by our participants: addressing the socioeconomic determinants of mental health. The link between socioeconomic deprivation and mental illness is one that has been supported

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[102] Michael Smith, "Capability and Adversity: Reframing the 'Causes of Causes' for Mental Health," *Palgrave Communications* 4 (2018), https://www.nature.com/articles/s41599-018-0066-z, accessed 21 May 2018.

[103] Sarah Couper and Phil Mackie, *'Polishing the Diamonds': Addressing Adverse Childhood Experiences in Scotland* (Glasgow: Scottish Public Health Network, 2016), https://www.scotphn.net/wp-content/uploads/2016/06/2016_05_26-ACE-Report-Final-AF.pdf, accessed 22 May 2018.

by a great deal of research stretching back many decades (at least to the work of Faris and Dunham in the 1930s), but governments have not often been willing to translate such theories into practice. It could be argued that an exception to this was the mental health reforms of the Kennedy and Johnson administrations in the US, but these involved changing the mental health system, rather than American society itself.[104] Nevertheless, one of the recommendations made by our participants was also articulated by mental health reformers during the 1960s, namely, establishing a universal basic income (UBI), which would guarantee a basic standard of living to all. A UBI would not only help to reduce poverty and inequality, but also empower individuals to seek out more meaningful forms of work, including entrepreneurial activities, caring for relatives and volunteering for causes important to them. As a number of trials are indicating, people who receive UBI often experience reduced levels of stress, as well as other health benefits.[105] Given that common mental health conditions, such as depression, are often co-morbid with other costly chronic diseases, it is time to consider such bold and systemic policy changes if we are serious about preventive medicine and public health. Lobbying for a shift in government policies could help counter the structural discrimination which Long identifies as a significant issue which stigmatises service users.[106] Indeed, socioeconomic determinants should be viewed as contributory factors in both primary and tertiary prevention, pointing to the need to view both agendas as complementary, and to resist calls to artificially pit one against the other. We should be campaigning for adequate funding to support all aspects of mental health prevention and care, rather than unwittingly collude in the defunding of mental health care by advocating for support of one aspect at the expense of another.

The potential benefits of policies, such as UBI, may well have significant implications for the mental health of subsequent generations as well. Intriguing results in relation to mental ill-health and epigenetic change have emerged from the 'Dutch Hunger Winter Families Study',

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[104] Smith, "A Fine Balance."

[105] Arne Ruckert, Chau Huynh, and Ronald Labonté, "Reducing Health Inequities: Is Universal Basic Income the Way Forward?," *Journal of Public Health* 40 (2018), 3–7; Amy Downes, "Basic Income Is One Solution to Our Growing Mental Health Crisis," *The Independent* (12 May 2017), https://www.independent.co.uk/voices/basic-income-finland-stress-mental-health-solution-a7732006.html, accessed 22 May 2018.

[106] Long, *Destigmatising Mental Illness?*, Conclusion.

and associated famine projects.[107] These studies suggest that nutritional deprivation at specific points in gestation may have profound implications for the development of substantive mental illness in adulthood. Given the prevalence of man-made as well as natural famine disasters worldwide, the specific targeting of certain famine-afflicted cohorts may play a major role in mental illness prevention. It is not just in the developing world, or regions of civil strife, that these associations are found, however. Research amongst economically deprived areas of the north of England and north-east Scotland has identified children who are simultaneously obese and malnourished, with early indications of elevated levels of mental ill-health linked to nutritional deprivation in gestation and early childhood.[108] Early intervention can alleviate, and even reverse, the epigenetic impact, but requires a targeted and inevitably expensive support system that has historically been unpopular with politicians with an eye on the next election. But there is some encouraging work in relation to depression that returns to the long-held belief in the importance of a mind-body balance. Work in Ireland on the 'gut-brain axis' is demonstrating how intestinal bacteria play a crucial role in precipitating, and preventing, major depression.[109] This new field of 'psychobiotics' offers hope of large-scale improvements in the prevention of mental illness by literally following our gut instincts. It also serves as an intriguing example of the cyclical nature of psychiatric thought. As this volume highlights, many initiatives in the field of preventive mental health care evolved out of the development of social psychiatry in the twentieth century. Epigenetic research, however, merits comparison

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[107] L. H. Lumey et al., "The Dutch Hunger Winter Families Study," *International Journal of Epidemiology* 36, no. 6 (December 2007): 1196–204; Marcus Pembrey et al., "Human Transgenerational Responses to Early-Life Experience: Potential Impact on Development, Health and Biomedical Research," *Journal of Medical Genetics* 51, no. 9 (2014): 563–72; Rachel Yehuda et al., "Holocaust Exposure Induced Intergenerational Effects on FKBP5 Methylation," *Biological Psychiatry* 80, no. 5 (September 2016): 372–80.

[108] Steve Turner, "Obesity Linked with Malnutrition and Poverty," (April 2014), https://www.abdn.ac.uk/news/6187/, accessed 19 May 2018.

[109] John Kelly et al., "Transferring the Blues: Depression-Associated Gut Microbiota Induces Neurobehavioural Changes in the Rat," *Journal of Psychiatric Research* 82 (July 2016): 109–18; Timothy Dinan et al., "Psychobiotics: A Novel Class of Psychotropic," *Biological Psychiatry* 74, no. 10 (2013): 270–76; T.G. Dinan and John F. Cryan, "Melancholic Microbes: A Link Between Gut Microbiota and Depression?," *Neurogastroenterology and Motility* 25, no. 9 (2013): 713–19.

with late nineteenth- and early twentieth-century psychiatric approaches, which also stressed the interplay of genetic and socio-economic factors: the novelty in part stems from the utilisation of this understanding to outline new ways of preventing mental illness.

Exploring the role of epigenetics in mental health connects to the third and final category of recommendations made by our participants, specifically, increasing the amount of research devoted to investigating the wide range of factors implicated in the onset of mental illness and how to eradicate them. Although a great deal of funding was allocated to epidemiologic studies during the early years of the National Institute of Mental Health in the US, for instance, funding in subsequent decades has gravitated increasingly towards treatment and, chiefly, the development of new drugs. As Nicolas Henckes has recently argued in his provocatively titled chapter, 'Magic Bullet in the Head', such investment has not been as beneficial as the proponents of psychopharmacology have claimed.[110] Our conference participants believed that research should focus instead on two areas: (1) exploring new or under-researched explanations for mental illness, and (2) exploring how to implement more established findings. The first category could include factors ranging from perinatal trauma and sport-related head injuries to the role of atmospheric pollutants, food chemicals and high THC cannabis in specific disorders. On the one hand, the role of some specific factors, such as atmospheric lead, are relatively well established, but further research is needed to determine the full implications of such findings (for example, whether other chemicals in our environment may cause mental health problems). On the other hand, there is a need for much more open-minded and creative research that investigates unexpected causes. Often history can be a good starting point for such explorations. There is a clear link, for instance, between recent interest in the role of inflammation in depression and research on the relationship between allergy and mental health problems that dates back to the early twentieth century.[111]

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[110] Nicolas Henckes, "Magic Bullet in the Head? Psychiatric Revolutions and Their Aftermath," in *Therapeutic Revolutions: Pharmaceuticals and Social Change in the Twentieth Century*, eds. Jeremy A. Greene, Flurin Condrau, and Elizabeth Siegel Watkins (Chicago: University of Chicago Press, 2016), 65–96.

[111] Matthew Smith, *Another Person's Poison: A History of Food Allergy* (New York: Columbia University Press, 2015); Carmine Pariante, "Why Are Depressed Patients Inflamed? A Reflection on Twenty Years of Depression, Glucocorticoid Resistance and Inflammation," *European Neuropsychopharmacology* 27 (2017): 554–59.

The second area of research—determining how to implement such research findings—may require just as much imagination and blue-sky thinking but is no less necessary. Most theories about how to prevent mental illness do not lend themselves to simple or easily implemented policies. We know, for example, that children who experience sexual abuse have a higher chance of struggling with mental health problems. Knowing that does not make the prevention of sexual abuse any easier. Moreover, as this volume demonstrates, the causes of mental illness are numerous. While a progressive policy, such as a UBI, might have the potential to make a considerable dent in checking mental illness, it should not be implemented on its own, nor will the suspected benefits that come with it occur immediately. The prevention of mental illness requires both a faith in what research findings suggest and a willingness to invest in the mental health of subsequent generations.

Above all, our conference participants and the contributors to this volume were convinced that the prevention of mental illness should be a far greater priority for researchers, clinicians, policy makers, politicians and society more generally than it is at present. As the history of preventing mental illness demonstrates, it has only been in recent decades that prevention has not taken a central role in discussions about mental health and illness. We hope that this volume helps to put prevention back in the forefront of mental health research and policy. Although the chapters that follow indicate that the path to prevention is neither easy nor straightforward, it would be madness not to embark upon it.

CHAPTER 2

Imagination and the Prevention of Violence: Fredric Wertham, Mass Media and Mental Hygiene, 1946–1958

Dennis Doyle

Introduction

In 2009, the Walt Disney Company purchased Marvel Comics. When the merger was announced, few found it disconcerting that the House of Mouse now owned the house that Stan Lee built. Yet in 1954, Americans—including psychiatrist Fredric Wertham—might have been appalled by a merger between Disney and a comic book company. Comics and Disney's films were not considered equivalent entertainment then. While Walt Disney was busy overseeing the construction of Disneyland and preparing for his first television show's debut, the U.S. Senate held hearings to determine if comics caused crime. Disney's movies were considered harmless, but Wertham contended that comic books damaged a child's psyche. For fans today, the late psychiatrist was a villain bent on destroying the medium that spawned the billion-dollar *Avengers* superhero film franchise. In his 1954 book *Seduction of the*

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Innocent, Wertham argued that comic books caused violence. As a mental hygiene measure, he recommended that children should not be exposed to comic books. But not all psychiatrists agreed.

This chapter examines two post-war US psychiatrists who weighed in on comic books and their relationship to preventive psychiatry. Wertham was the best-known comic book opponent, arguing that violence could be prevented by banning the sale of comic books to minors. Lauretta Bender was one of the comics industry's keenest defenders.[1] Bender served as a paid consultant for DC Comics, the publisher of *Wonder Woman*, *Superman* and *Batman*. She claimed that comics prevented juvenile delinquency because they allowed children to work out internal conflicts that might otherwise have led them to act out. Both clinicians framed the relationship between comics and violence in terms of preventive psychiatry. In so doing, both corroborate Michael Staub's contention that post-war psychological experts claimed a duty to protect the public from an unhealthy society.[2] Through child guidance and mental hygiene, psychiatrists positioned themselves as authorities best suited to help citizens avoid mental health risks.[3] Bender and Wertham assumed responsibility for educating the public on the benefits and dangers of the mass media—including comics, radio, television and movies.

Their shared sense of social responsibility notwithstanding, I argue that Wertham and Bender diverged on the matter of mass culture's threat to mental health partly because they disagreed as to what imagination was and the role it played in child development. A substantial historiography on the social construction of imagination does not exist. Histories of childhood have tracked changes in attitudes towards imagination.[4] But there is no established history of how Americans have

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[1] Jill Lepore, *The Secret History of Wonder Woman* (New York: Knopf, 2014).

[2] Michael E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948–1980* (Chicago: University of Chicago Press, 2011).

[3] Ellen Herman, *The Romance of American Psychology: Political Culture in the Age of Experts* (Berkeley: University of California Press, 1996); Peter N. Stearns, *Anxious Parents: A History of Modern Childrearing in America* (New York: New York University, 2003); Mical Raz, *What's Wrong with the Poor? Psychiatry, Race, and the War on Poverty* (Chapel Hill: University of North Carolina Press, 2013).

[4] Steven Mintz, *Huck's Raft: A History of American Childhood* (Cambridge, MA: Belknap Press, 2000); Henry Jenkins, ed., *The Children's Culture Reader* (New York: New York University Press, 1998); Jacqueline S. Rose, *The Case of Peter Pan: The Impossibility of Children's Fiction* (Philadelphia: University of Pennsylvania Press, 1992).

defined imagination. Partly this is because mental health experts have never made a sustained serious study of the human mind's capacity to generate its own self-contained visual field. In the United States at least, a discipline devoted to it and jargon for describing it never emerged.[5] Without a shared discourse however, psychiatrists widely differed as to what they assumed imagination was and how one could prevent any harm from befalling it.

Consequently, Bender thought of imagination as a resilient mental space that could not be harmed by comic books, whereas Wertham considered it to be far more fragile and almost mystical in nature. Bender and most post-war psychological experts understood imagination as an active mental workshop in which children safely made sense of the real world. Children were in control of the images that crossed their mind's eye. Comic book reading might even prevent violence by giving children an imaginative outlet for violent urges. In contrast, Wertham assumed that children could not determine which images did and did not infiltrate their imaginations. He conceived of imagination as a place of innocence that could provide children with a healthy, uplifting escape from the disappointing real world. Nevertheless, imagination could only serve this purpose as long as children were shielded from harmful images of violence, crime and sexual deviance found in comic books.

I also contend that Wertham's anti-comics crusade gained popularity because his understanding of imagination and its role in a consumer society resonated with a public that made Walt Disney's products its standard of acceptable fantasy worlds for children. Wertham asserted that the European fairy tale was the art form optimally suited to satisfy the imagination's need for wholesome entertainment. Disney adapted those fairy tales to film. Stripping them of the sort of violent and sexual content Wertham objected to in comic books, Disney created storylines and visuals for his fairy tales that reflected a view of imagination as innocent, pure and attuned to normative Victorian values. Not only was this vision similar to Wertham's, but it also resonated in the marketplace where Disney expanded his film franchise into the realms of amusements and television.

The comic book scare was more than Cold War anxiety over mass culture and its threat to American minds. Partly, the comic book backlash

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[5] Antonio Damasio, "How the Brain Creates the Mind," *Scientific American* 281 (1999): 74–79.

reflected a pervasive fear that the psyche was vulnerable to brainwashing, hidden messages in advertising and other misuses of mass communication.[6] Nevertheless, Wertham's comic book campaign appealed to families for the same reason that Disney's films had become popular: childhood imagination and fantasy had become central to post-war Americans' conception of themselves as citizens and consumers. To tell that story, this chapter begins with an investigation of Wertham's comic book campaign, transitions into an analysis of Bender's view of imagination and her support for comics and then concludes with examinations of Wertham and Disney's conception of imagination and its need for both healthy stimulation in and protection from the marketplace.

Preventing Violence: Psychiatry and the Threat of Comic Books

This battle over comic books began when sequential art was still a brand-new medium. In 1933, Eastern Colour Printing Company started printing magazine-sized reprints of comic strips from U.S. newspapers. Comics with new content were first sold at newsstands in 1935. Yet it was not until Superman debuted in 1938's *Action Comics* # 1 that publishers regularly sold titles with original, reoccurring characters.[7] The popularity of super-powered, costumed vigilantes helped the medium become an overnight success, especially with children.[8] In 1952, the peak of business, the top five titles each sold between 1.5 and 4 million copies a month on average. Comics were a hugely profitable industry with new companies debuting every year since Superman first bounded over Metropolis.[9]

Criticism of comics emerged not long after the Man of Steel's first appearance. Partly, this was simply because they 'were one of the first

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[6] Matthew W. Dunne, *A Cold War State of Mind: Brainwashing and Postwar American Society* (Amherst: University of Massachusetts Press, 2013); Andrea Friedman, "Sadists and Sissies: Anti-pornography Campaigns in Cold War America," *Gender & History* 15 (August 2003): 201–27.

[7] Bradford W. Wright, *Comic Book Nation: The Transformation of Youth Culture in America* (Baltimore, MD: Johns Hopkins University Press, 2003).

[8] Mintz, *Huck's Raft*, 249.

[9] "Prices and Questions," *Wizard: The Comics Magazine* 148 (February 2004): 163.

products directly marketed to young people…'.[10] Most children consumed them outside of their parents' presence. Given their ubiquity and adults' ignorance of their contents, some critics speculated that they might be exerting some undue influence on children. Before World War II, those critics generally did not claim that comics caused children to misbehave. Instead, parents, educators and librarians worried that this cheap, lowbrow medium would replace books and magazines as the U.S.'s chosen form of literature.[11] Critics declared the panels 'badly printed and inartistically drawn', the characters ridiculous, and the stories hackneyed, crude and brutal.[12] They feared that these things would coarsen the culture, causing reading skills to decline. After the war, psychiatrist Wertham shifted the concern over comics into the realm of mental hygiene.

In magazine articles and books published between 1948 and 1957, Dr. Wertham argued that comic books taught some children how to misbehave. Utilising a rather crude and inexact behaviourist argument, Wertham claimed that comics hijacked children's imaginations. For frequent readers, comic book panels imprinted themselves upon on the mind's eye, displacing other visual influences and memories. These images included visual representations of crime, violence, sexual perversion and poor relationships. A steady diet of this fare infected a child's imagination, conditioning the worst affected to imitate the panels they saw.[13]

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[10] Mintz, *Huck's Raft*, 248.

[11] Bart Beaty, *Fredric Wertham and the Critique of Mass Culture* (Jackson: University of Mississippi Press, 2005); Amy Kiste Nyberg, *Seal of Approval: The History of the Comics Code* (Jackson: University of Mississippi Press, 1998).

[12] Fredric Wertham, *Seduction of the Innocent* (New York: Rinehart, 1954), 36.

[13] James Gilbert, *Cycle of Outrage: America's Response to the Juvenile Delinquent in the 1950s* (New York: Oxford University Press, 1986), 29–31; Nyberg, *Seal of Approval*, 20–21; Fredric Wertham, "Puddles of Blood," *Time* 51 (March 29, 1948): 67; Hilde Mosse, "Aggression and Violence in Fantasy and Fact," *American Journal of Psychotherapy* 2 (April 1948): 477–82; Fredric Wertham, "The Psychopathology of Comic Books," *American Journal of Psychotherapy* 2 (April 1948): 472–73; Fredric Wertham, "The Comics…Very Funny!" *Saturday Review of Literature* 31 (May 29, 1948): 29, 95; Judith Crist, "Horror in the Nursery," *Collier's Magazine* (March 27, 1948): 22–23; Fredric Wertham, "What Parents Don't Know About Comic Books," *Ladies Home Journal* 70 (November 1953): 50–53; Fredric Wertham, "The Curse of the Comic Books," *Religious Education* 49 (November–December 1954): 12–15; Fredric Wertham, "Do the Crime Comic Books Promote Juvenile Delinquency?," *Congressional Digest* 33 (December 1954): 302.

Wertham's perspective gained a rabid following among white conservatives, prompting the U.S. Senate to hold high-profile hearings on the comic book-crime link in 1950 and 1954. Testifying before Senate Sub-Committee on Juvenile Delinquency as an authority on child psychiatry, Wertham forcefully argued that the unregulated sale of the most offensive comics constituted a public health risk to minors. Fearful of government regulation, the comic book industry opted for self-regulation with the creation of the Comic Magazine Association of America's Comics Code in 1954. Parents and civic leaders were satisfied that industry self-censorship would produce a product less injurious to the imaginations of U.S. children.[14]

Despite his popularity and influence as a public intellectual in the post-war U.S., Wertham's claim that comic books threatened mental health was not an orthodox position within the psychological sciences. Wertham was used to being an outsider within psychiatry. Dismissive of authority, hierarchies and protocols, he rarely lasted with any one employer before alienating his superiors. A former student of German psychiatric innovator Emil Kraepelin, Wertham, a Jew born Fredric Wertheimer in 1885, became a physician in 1921. He left the inflation-wracked Weimar Republic the following year. In the United States, he shuffled from institution to institution, working first at Johns Hopkins' Phipps Clinic, then at New York's Bellevue and finally Queens Mass General Hospital. Perennially willing to take unpopular stands, Wertham championed the use of psychotherapy with the criminally insane, supported humane care for homosexuals, called for the end of violence, and opposed Jim Crow. Within his profession, Wertham also displayed a rare willingness to translate advocacy into action, using his authority to help desegregate Delaware's public schools and provide African Americans in Harlem with low-cost care at the Lafargue Mental Hygiene Clinic he co-founded in 1946.[15]

Wertham's comic book campaign was perhaps his most infamous divergence from the psychiatric profession. Most clinicians steered clear of the divisive issue, so writer Norbert Muhlen's 1949 contention

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[14] Gilbert, *Cycle of Outrage*, 143–62; Nyberg, *Seal of Approval*, 135.

[15] Gabriel Mendes, *Under the Strain of Color: Harlem's Lafargue Clinic and the Promise of an Antiracist Psychiatry* (Ithaca, NY: Cornell University Press, 2015); Andrea Friedman, *Citizenship in Cold War America: The National Security State and the Possibilities of Dissent* (Amherst: University of Massachusetts, 2014); James E. Reibman, "Introduction," in *Seduction of the Innocent* (1954; repr., New York: Main Road, 2004), v–xxxvii.

in *Commentary* that Wertham had triggered a 'civil war among psychiatrists' was most likely an overstatement.[16] To be sure, Wertham's claim that comic books caused juvenile delinquency had convinced some psychiatrists and analysts. Winfred Overholser, superintendent of St. Elizabeth's Hospital in Washington DC, was perhaps the most prominent psychiatrist outside of New York to publicly support *Seduction of the Innocent*'s argument in 1954.[17] But most of Wertham's most ardent supporters were those closest to him. These psychiatrists and therapists were either co-workers of his, such as Hilde Mosse, Paula Elkisch and Charles Collins, or other New York clinicians in Wertham's orbit, including Harris Peck and Marvin Blumberg.[18] While most psychiatrists stayed silent on the issue, there is enough evidence to suggest that Wertham's argument was not universally welcomed. Under the direction of psychiatrist George S. Stevenson in 1953, the National Association for Mental Health declared that comic books did not cause juvenile delinquency.[19] The editors of New York's State Department of Mental Hygiene's *Psychiatric Quarterly* dismissed the comic book hysteria in 1954, arguing that Wertham never proved that comic books caused children to misbehave.[20] In a survey, the U.S. Senate's Committee on Organised Crime had conducted of psychological experts in 1950, 60 per cent of respondents claimed that there was no link between comic books and crime.[21] What is more, some clinicians, including Lauretta Bender and the New York Bureau of Child Guidance's Jean Thompson, even claimed that comic books could promote child development.[22]

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[16] Beaty, *Fredric Wertham*, 152.

[17] Ibid., 150.

[18] Nyberg, *Seal of Approval*, 59; Mosse, "Aggression and Violence in Fantasy and Fact"; Beaty, *Fredric Wertham*, 122; "Discussion," undated transcript of dialogue held at Park Central, 7th Ave., 1–8, folder 14, Box 3, Dr. Fredric Wertham Papers, Manuscript Division, United States Library of Congress, Washington, DC [Hereafter Wertham Papers].

[19] Beaty, *Fredric Wertham*, 125.

[20] Duncan Whitehead, "Touch Tempora, Worse Mores," *Psychiatric Quarterly* 28 (1954): 496–510; Review of *Seduction of the Innocent*, by Fredric Wertham, 28 (1954): 516.

[21] Nyberg, *Seal of Approval*, 54.

[22] U.S. Congress, Senate, Special Committee to Investigate Organized Crime in Interstate Commerce, *A Compilation of Information and Suggestions Submitted to the Special Senate Committee to Investigate Organized Crime in Interstate Commerce Relative to the Incidence of Possible Influence Thereon of So-Called Crime Comic Books During the Five-Year Period 1945–1950*, 81st Congress, second session, 1950, 182–184; 189–90.

The root of this apparent divide was Wertham's unorthodox understanding of the imagination. Given that Wertham and his supporters believed that mass culture could corrupt and manipulate a child's imagination so easily, what did he think imagination was exactly? Before I launch into an exploration of Wertham's conception of imagination, it will help us to first analyse what the comic book industry's defenders assumed that imagination was. For that we must turn to one of the leading U.S. child psychiatrists of the 1940s and 1950s: Lauretta Bender.

Lauretta Bender, Comic Books and the Orthodox Psychological Perspective on Imagination

Lauretta Bender was a pioneering child psychiatrist who had served at Bellevue since 1930. An early proponent of the diagnosis of childhood schizophrenia, Bender began heading up the children's ward in 1934. In 1940, Bender first presented her claim that comics were a positive influence on children. In 1941, a comic book publisher's group now known as DC Comics contacted her. From 1942 to early 1944, she 'unofficially advised' DC and on 25 February 1944, she began an official relationship with them.[23] From 1944 to September 1954, she served as a paid consultant on their Editorial Board, receiving a $100 retainer's fee and three copies of every monthly comic book title, including *Wonder Woman*, *Batman* and *Superman*. In her decade of service, she generally reviewed and commented on either advance issues or ones that had already gone to press. DC executives Harry Childs and Max Gaines called upon her to help defend them publically or to craft letters allaying the fears of private citizens and civic groups.[24]

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[23] Lauretta Bender to Dr. Iago Galdston, March 2, 1944, file 6, box 16, series 7, Lauretta Bender Papers, Archives, Brooklyn College Library, Brooklyn, New York [Hereafter LBP].

[24] Harry E. Childs to Lauretta Bender, February 25, 1944, file 2, box 16, series 7, LBP; Harry E. Childs to Dr. Lauretta Bender, February 28, 1944, file 2, box 16, series 7, LBP; Lauretta Bender to Harry E. Childs, March 1, 1944, file 2, box 16, series 7, LBP; Bender to Galdston; Iago Galdston to Dr. Lauretta Bender, March 6, 1944, file 2, box 16, LBP; M. C. Gaines to Dr. Max Winsor, May 22, 1944; Lauretta Bender to M. C. Gaines, July 18, 1944, file 2, box 16, series 7, LBP; M. C. Gaines to Lauretta Bender, August 14, 1944, file 2, box 16, series 7, LBP; M. C. Gaines to Lauretta Bender, October 27, 1944, file 2, box 16, series 7, LBP; Lauretta Bender to M. C. Gaines, file 2, box 16, series 7, LBP; Harry E. Childs to Lauretta Bender, file 6, box 16, series 7, LBP; Lauretta Bender to Harry E. Childs, August 3, 1950, file 6, box 16, series 7, LBP; J. S. Liebowitz to Lauretta Bender, September 7, 1954, file 6, box 16, series 7, LBP; Lauretta Bender to J. S. Liebowitz, September 17, 1954, file 6, box 16, series 7, LBP.

Bender was adamant that comic books did not cause violence. She was convinced that they even helped prevent it. According to Bender, 'this relationship is a positive one in that comics can be and are used by children as a means of relief from conflict, confusion, frustration, anxiety, and may prove also to be a various release of aggression'.[25] Presenting her findings in a frame that combined psychodynamic theory and Gestalt psychology, Bender claimed that children were not passively held in thrall by comic book imagery. Treating comics like any of the 'spectator arts',[26] she found that 'children show a remarkable capacity to select from the comics material they need and can use'[27] in their maturation. According to her, children actively choose from the world around them, latching onto whatever helps them understand their life situation, manage aggressive impulses and develop a sense of self.[28] For the moment, comics were a large part of that world and a natural fit for a child's psyche.

Why did Bender see comics so differently? One of the major points of difference between Wertham and Bender was the nature of imagination. According to some psychiatrists in the 1930s and 1940s, imagination was a naturally wild space divorced from reality, a place of escapism that had to be harnessed or suppressed as one matured. Withdrawing too often into fantasy could seriously impair one's personality development and social adjustment.[29] In contrast, Bender saw imagination not as a flight from reality or as a primitive faculty that needed taming.

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[25] U.S. Congress, Senate, Special Committee to Investigate Organized Crime, 183.

[26] Lauretta Bender, "The Psychology of Children's Reading and the Comics," *Journal of Educational Sociology* 18 (December 1944): 225.

[27] U.S. Congress, Senate, Subcommittee on Juvenile Delinquency, *Juvenile Delinquency (Comic Books): Hearings Before the Senate Subcommittee on Juvenile Delinquency*, 83rd Congress, second session, April 21–22, 1954 and June 1954, quoted in Michael T. Gilbert, "Mr. Monster's Comic Crypt," *Alter Ego* 3 (January 2010), 65.

[28] Bender, "The Psychology of Children's Reading and the Comics," 223–26, 229; Lauretta Bender and Reginald Lourie, "The Effect of Comic Books on the Ideology of Children," *American Journal of Orthopsychiatry* 11 (July 1941): 543, 544, 546–47, 548–49.

[29] Lawrence Kubie, "Psychiatry and the Films," *Hollywood Quarterly* 2 (January 1947): 113–17; Ernst Kris, "Psychoanalysis and the Study of Creative Imagination," in *The Creative Imagination: Psychoanalysis and the Genius of Inspiration*, ed. Hendrick M. Ruitenbeck (Chicago, IL: Quadrangle, 1965), 28–30; Lauretta Bender and Harry H. Lipkowitz, "Hallucinations in Children," *American Journal of Orthopsychiatry* 10 (July 1940): 470–71; Lauretta Bender and Frank Vogel, "Imaginary Companions of Children," *American Journal of Orthopsychiatry* 11 (January 1941): 56.

For her it was a productive faculty intended by nature to help children facilitate emotional maturation. Rather than a space divorced from reality, the imagination was where children worked through their internal conflicts and made sense of the world around them.[30] In the imagination, children converted real-world stimuli into mental constructs they controlled, shaping them into comforting fantasies—especially 'phantasies of omnipotence'.[31] According to Bender, fantasies 'were a constructive approach to reality' enabling the child to become less afraid of the world, more emotionally secure.[32] As an individual gained a firmer sense of self and became more socially competent, she would grow out of this reliance on fantasy and imagination. In childhood though, Bender stated: 'All the evidence points to the complete normality of the fantasy life in any normal child…'.[33]

Bender's view of imagination was supported by experimental psychologists. Surveying his field's literature in 1952, Edgar Vinacke, the co-founder of the Society of Experimental Social Psychology, found that his colleagues regarded imagination as a form of 'thinking' that took place largely but not only in the form of mental images. Most of those researchers considered imagination to be thinking related 'to the internal needs and conditions of the individual'.[34] Like Bender, these experimental psychologists also regarded it as 'usually normal and constructive, serving as a mechanism to aid in adjusting to the environment'.[35] They also agreed that a fantasy life—working in concert with other mental processes such as perception, learning, problem solving and personality development—was essential to normal maturation.[36]

Bender claimed that comic books could promote normal maturation by stimulating the fantasy life of normal children. Her confidence in the efficacy of comics stemmed from her sincere conviction that the new medium engaged the imagination in exactly the same the way folklore had. Both primarily offered up 'phantasies of omnipotence', which helped children learn 'that we can have a good influence on the world,

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[30] Bender, "Imaginary Companions," 64.

[31] Bender, "The Effect of Comic Books," 546.

[32] Bender, "Hallucinations in Children," 472.

[33] Bender, "The Effect of Comic Books," 546.

[34] W. Edgar Vinacke, *The Psychology of Thinking* (New York: McGraw Hill, 1952), 195.

[35] Ibid., 211.

[36] Ibid., 198–214.

and that we can be protected by the powerful influences in the world'. Fairy tales, legends, myths and now comics all supplied children with plenty of useful fantasy material to help them figure out how to navigate their environment with confidence. In fact she thought comics had more to offer in that regard because their content was more contemporary. Yes, both myth and comics provide the same range of universally resonant symbols able to stand in for the 'fundamental human problems' children have to resolve as they mature. Fairy tales and myths relied on the old narrative devices of 'magic' or 'enchantment' to build the secondary world in which a fantasy of omnipotence could be sustained. But Bender found that modern children were likely to suspend disbelief in invented worlds rooted in science-fiction elements such as superpowers, aliens, mad scientists and futuristic technologies.[37] As she told the head of All-American Comics, '[I] feel that fantasy material is the most constructive and important contribution that the comics can make to the psychological development of children'.[38] Comics were, in her words, America's modern mythology, 'the folklore of this age'. This comics/folklore link became a rallying cry in the industry's defence of its product.[39]

Fredric Wertham and the Protection of Imagination

Nothing comic book defenders said aroused Fredric Wertham's ire more than the claim that comics were modern folklore. To him, this was the falsest of false equivalencies, prompting him to tell one supporter that 'defenders of comic books (of which there are many in unexpected places) have maligned and defamed fairy tales'.[40] Mass culture's critics, including the Frankfurt School's Theodor Adorno, were not persuaded by this kind of comparison either. Wertham and many of the German fathers of critical theory understood capitalist mass culture as mere commodities that bore

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[37] U. S. Congress, Senate, Subcommittee on Juvenile Delinquency, *Juvenile Delinquency (Comic Books): Hearings Before the Senate Subcommittee on Juvenile Delinquency*, 83rd Congress, second session, April 21–22, 1954 and June 1954, quoted in Michael T. Gilbert, "Mr. Monster's Comic Crypt," *Alter Ego* 3 (March 2010): 61.

[38] Bender to Gaines, November 16, 1944, LBP.

[39] Bender, "The Effect of Comic Books," 546.

[40] Fredric Wertham to Just Lunning, January 7, 1955, folder 14, Box 53, Wertham Papers.

no relation to the 'folk'.[41] As Wertham wrote in 1953: Comics 'are not authentic creations of the people, but are planned and concocted. They do not express the genuine conflicts and aspirations of the people…'.[42] Instead, Superman's 'new adventures are dictated by advertising men'.[43] Divorced from the 'memory of mankind' that generated fairy tales and classic myths, the mass-produced comics were devoid of symbolism, moral centre and timeless truths about the human experience.[44] Wertham claimed that authentic folklore brought out a child's 'real nature', developing her 'true personality', something comics could not.[45]

So how was this supposed to happen, fairy tales tapping into the real us? According to Wertham, they did this by engaging the imagination in ways comics could not. The imagination of Wertham was not Bender's neo-Freudian model of an active, structured workshop making constructive use of whatever sense impressions the world offered. Imagination did not mould reality. Reality moulded the imagination. Yet contrary to what some of his critics erroneously claimed, he did not consider the imagination a blank slate on which either bad or good influences could be imprinted.[46] Psychological theory did not primarily shape his conception of imagination's structure. Instead, his sources came from Romantic literature. A committed humanist, his notion of imagination's structure resembled that of English poet Samuel Taylor Coleridge. Coleridge divided up the imagination into two halves: one, a passive repository of images received and projected on the mind's eye in a 'mechanical' way, and another, a mysterious place where creativity thrived.[47]

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[41] Gilbert, *Cycle of Outrage*.

[42] Wertham, *Seduction of the Innocent*, 232.

[43] Fredric Wertham's notes on Louise Bechtel's *Books in Search of Children*, [1946?], Folder 11, Box 42, Wertham Papers.

[44] Fredric Wertham, "Reading for the Innocent," 2, reprint of *Wilson's Library Bulletin*, 2, folder—Articles by Fredric Wertham, Hilde L. Mosse, and Others, box 2, Lafargue Clinic Records, Manuscripts, Archives, and Rare Books Division, Schomburg Center for Research in Black Culture, New York Public Library, Astor, Lennox, and Tilden Foundation, New York [Hereafter LFC-SCRBC].

[45] Wertham, *Seduction of the Innocent*, 233, 248.

[46] Jed Rasula, "Nietzsche in the Nursery: Naïve Classics and Surrogate Parents in Postwar American Cultural Debates," *Representations* 29 (Winter 1990): 70.

[47] David Beres, "Communication in Psychoanalysis and in the Creative Process: A Parallel," in *The Creative Imagination*, 211; Samuel Taylor Coleridge, *Biographia Literaria* (Edinburgh: University of Edinburgh, 2014), 199–206, 213–14.

Wertham understood imagination in similar terms. Children learned by receiving sense impressions. These sense impressions were stored as mental pictures. Learning and maturation proceeded in reference to these images. In general, it did not matter if these impressions originated as representations or as real objects as long as they were presented as 'realistic' to the child. According to Wertham: 'Modern psychopathology, however, teaches that it is not the form but the content that is dynamically important' in the reception of sense impressions.[48] Wertham, a Romantic humanist himself, described the process by which a child's mind received violent imagery in comics using the same term Coleridge had—'mechanical'.[49] Unlike Bender, Wertham believed children had no control over which images entered their imaginations and which did not. Instead a product was implanted or inserted and passively received.[50] 'Endless repetition'[51] of these unsolicited images solidified them within imagination, making them likely to function as agents of conditioning. According to Wertham, the comics' 'influence consists in the continuation or repetition of the contents of the stories in life, either in thought or in action'.[52]

What drove Wertham most was his conviction that the imagination's 'true nature' was not as this passive repository of violent imagery, but as a place of morally uplifting escape. In this way, Wertham's conception of imagination's purpose harkens back to the late Victorian and early Edwardian Era. U.S. psychologist G. Stanley Hall's child study movement of the 1890s–1920s had been the first systematic effort to scientifically research and analyse children's emotional development.[53] Child study experts placed an 'emphasis on the importance of children's imagination' in the process of maturation.[54] Although Wertham did not cite their influence on his thinking, late Victorian thinkers—including some

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[48] Wertham, *Seduction of the Innocent*, 86.

[49] Ibid., 117.

[50] Ibid., 86, 99, 109, 139, 171, 357, 365, 377.

[51] Ibid., 95.

[52] Ibid., 115.

[53] Ellen Condliffe Lagemann, *An Elusive Science: The Troubling History of Education Research* (Chicago: University of Chicago Press, 2000), 24–32, 39–50; Kathleen Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge, MA: Harvard University Press, 1999), 50–56.

[54] Mintz, *Huck's Raft*, 190.

child study experts—generally conceived of imagination in ways similar to his. Both tended to romanticise it as a place of naiveté that allowed children to mentally retreat from the disillusionment, dangers and hardships of the adult world. Within the safe space of the imagination children could find comfort in dreams and desires, doing so in ways that would not interfere with their work, studies, or character development. Like Wertham, many child study experts expected that their imaginations would be stimulated by stories that supported a naive view of the world. Not surprisingly, literary critics at the turn of the twentieth century advocated adventure books expressly written for children for their power to satisfy the imagination's hunger for escapist fare.[55]

Relying upon a common post-war metaphor, Wertham updated this Victorian conception of the imagination as a corruptible space by comparing it to plastic. By this he did not just mean that imagination could be moulded into a variety of shapes and textures. Some of the shapes and textures we forced plastic into did not always hold up very well over time. The sturdiest plastic products were the ones whose shape or texture best suited plastic's petroleum-based nature. Similarly, a child's imagination naturally sought to be filled with images that could help it generate a discrete internal world of fantasy conforming to society's highest ideals. According to Wertham, comics were incapable of inspiring mental worlds that could emotionally satisfy a child. Instead, comics triggered fantasies that—contained within the imagination—left the child feeling unfulfilled. Comics offered no catharsis. Instead, these unfulfilled fantasies leached over into children's lives, prompting them to satisfy their unmet sadistic desires in the real world.[56]

What stimuli did imagination require to generate an emotionally satisfying fantasy world? According to Wertham, authentic folklore did the trick. A voracious reader, even as a child, the psychiatrist was fond of European fairy tales. In 1955 he admitted to a supporter that: 'I love Hans Christian Andersen'.[57] For him, the fairy tale was an art form capable of unlocking humanity's potential. An admitted fan of Christian Platonists such as St. Augustine, Wertham believed people were endowed with a 'true personality', a blueprint for who they were meant to become under ideal conditions. If fed a steady diet of the right influences, the

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[55] Ibid., 76–77, 80, 83, 87, 93, 186, 190.

[56] Wertham, *Seduction of the Innocent*, 117, 171, 183.

[57] Wertham to Lunning, Wertham Papers.

imagination was equipped to help the psyche develop this true personality. For Wertham, fairy tales were the authentic, unmediated expression of human potential. When fairy tales entered the imagination, they activated that creative core Coleridge described. An internally consistent fantasy world opened up, revealing a human's capabilities.[58] Yet, these fantasy worlds inspired children not to simply reproduce what they visualised, but to play in creative, spontaneous ways. While the comics manipulated children in a mechanical way as though they were automatons, children controlled both their fantasy worlds and the 'spontaneous play'[59] they inspired. According to Wertham, 'children's real nature comes to the fore when they are given the chance to act out stories from genuine folklore and children's folk tales', not comics.[60]

So what was a child's real nature? Wertham believed that humans were naturally good. They desired 'cheer' and cooperation.[61] A child needs 'ethical principles to live by, he needs the concept and experience of loyalty and solidarity, of beauty, constructiveness, and productiveness, creative expression, the spirit of the family, and love'.[62] Aggression and violence were learned qualities. With 'social progress', Wertham believed, humans could abolish violence. The true nature Wertham described reflected 'a normal and not an abnormal set of human values'.[63] Wertham's use of the term 'normal' here is much closer in intent to the word 'normative', meaning what should be rather than what is.

Wertham was convinced that parents should raise children to thrive in the America that could be rather than America as it was. Wertham's conception of humanity's true nature and the U.S.'s potential was born of his progressive humanism, itself a product of nineteenth-century Romanticism and utopianism. Romanticism and utopianism were rooted in the assumption that humanity possessed an essential nature and destiny. This belief in essential subjectivities inspired Communism's concept of a pure worker consciousness. That idea found expression in Wertham's understanding of a fairy tale's influence on imagination.

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[58] Wertham *Seduction of the Innocent*, 232–33, 236–38, 362, 365; Wertham, "Reading for the Innocent," 2.

[59] Wertham, *Seduction of the Innocent*, 63, 365, 379, 380.

[60] Ibid., 233.

[61] Ibid., 244.

[62] Ibid., 248–49.

[63] Ibid., 236.

As an adolescent, Wertham had read and debated Karl Marx's Communist theory and history of industrial capitalism, developing a sense of social justice and an awareness of class conflict and its relationship to wealth inequality.[64] People, he learned, were not atomistic beings. They were social beings, sharing the same materialist interest in creating a better world.[65] As a clinician, he believed he had a duty to promote mental health, not as a way to adjust people to the status quo, but to help them to 'function in a changing world, and work with others to do it'.[66] He also found that fairy tales also were designed to reassure its audiences that a more equitable world was possible. Arguing that '[w]hat is true of fairy tales is true of living people', Wertham claimed that fairy tales 'represent the real struggle of the poor against bad people, feudal lords, oppressors, exploiters' and present the imagination with a vision of a more just future for everyone.[67]

For American parents, Wertham envisioned a more just marketplace that could actually help prevent social ills. Most of Wertham's readers did not share his rather muted Marxist materialism. But the psychiatrist and his fans did share another Victorian assumption: childhood innocence. To protect the innocent child's imagination from negative influences, he urged the U.S. government to ban the sale of comics to young children.[68] Speculating as to what a future America without juvenile comics readers would be like, Wertham offered a vision of a pruned marketplace where other mass media—television and film—could become 'indispensable instruments of what could be best in our culture', producing stories and images that could—almost by magic—stimulate imagination to fulfil its true potential.[69]

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[64] Reibman, "Introduction"; Mendes, *Under the Strain of Color*.

[65] Hilde Mosse, "Ideas for a Paper for International Congress of Psychiatry in Vienna, 1961," 22 July 1960, folder 13 "Ms. by Hilde Mosse, 1961," box 4, LFC-SCRBC.

[66] Kenneth Spencer, "Sans Funds, Lafargue Clinic Survives," *The People's Voice*, 13 July 1946, clipping, folder "Clipping re. Lafargue," box 3, LFC-SCRBC.

[67] Fredric Wertham, untitled and undated written notes on lined paper concerning a manuscript by Emanuel K. Schwartz [1956?]; Fredric Wertham, personally annotated reprint of Emanuel K. Schwartz, "A Psychoanalytic Study of the Fairy Tale," *American Journal of Psychotherapy* 10 (October 1956): 759–62; Fredric Wertham, notecard with annotations regarding manuscript by Emanuel K. Schwartz [1956?], folder 16, box 40, Wertham Papers.

[68] Wertham, "Comics…Very Funny!," 6, 29.

[69] Wertham, *Seduction of the Innocent*, 362. See also 355–56, 368–81.

The Wonderful World of Disney: Imagination and Fantasy for the Post-war U.S

The sentimental and mystical thinking expressed in Wertham's 1954 book *Seduction of the Innocent* was not expected of a clinician, but of an artist. At root, his conception of imagination was no different than the one that informed Walt Disney's feature-length animated films, especially his mid-century classics such as *Snow White and the Seven Dwarfs, Pinocchio, Fantasia, Alice in Wonderland, Peter Pan, Sleeping Beauty* and *Cinderella*. Drawing upon the same fairy tales Wertham praised, Disney Studios created highly profitable worlds of escapist fantasy, especially in his post-1945 cinematic features.[70] The protagonist triumphs over evil without having to compromise his beliefs and character, moving towards a comforting future anchored in romantic notions of humanity's true potential for peace, happiness and heterosexual marriage. Disney's filmic universe offered the uplifting fantasies Wertham believed the marketplace should offer children in place of the 'funny books'.[71]

Yet earlier in his career, Disney's animation did not have a reputation as escapist fluff that aligned with cloying sentimentalism and normative values. His 1928–1934 output—mostly animated shorts featuring frenetic, anthropomorphic animals and plants—actually appealed to leftist critics and artists. In these early 'Silly Symphonies', Disney pushed the visual envelope more than most other animators at the time, exploring a range of visual tricks and effects on screen.[72] One of his early champions, Soviet film auteur Sergei Eisenstein (director of *October* and *Ivan the Terrible*), admired the plasticity of his cartoon images, as characters changed shape and form and moved in ways not bound by the laws of physics.[73] Instead he thought that the 'protean' images of the early shorts stimulated audiences to plumb the depths of their own imaginations and think unconventionally.[74]

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[70] Eric Avila, *Popular Culture in the Age of White Flight: Fear and Fantasy in Suburban Los Angeles* (Berkeley: University of California Press, 2006), 120; Judith Wasko, *Understanding Disney: The Manufacture of Fantasy* (Malden, MI: Blackwell, 2001), 22, 171–72, 209–12.

[71] Neal Gabler, *Walt Disney: The Triumph of the American Imagination* (New York: Alfred Knopf, 2007), 204–10, 275–96; Wasko, *Understanding Disney*.

[72] Gabler, *Walt Disney*, 102, 200, 398; Wasko, *Understanding Disney*, 3, 111.

[73] Sergei Eisenstein, *Eisenstein on Disney*, ed. Jay Leyda and trans. Alan Upchurch (Calcutta: Seagull, 1986), 3–4, 8, 21, 39.

[74] Ibid., 21, 39, 43–46, 64.

But from 1934 onward, those leftist critics argued that Disney's impact on imagination—especially in his feature films such as *Snow White* and *Pinocchio*—had indeed become more restricted and moralistic. As the plots, tone and characterisation became conventional, the on-screen imagery achieved a higher degree of verisimilitude, leading fewer critics to claim that Disney's visuals pushed the imaginative envelope. Even some of his more conservative critics were not comfortable with the maudlin tragedy of his wartime films, especially 1941's *Dumbo* and 1942's *Bambi*—both of which feature characters that lost their mothers. Critics on both sides of the political spectrum urged Disney to return to escapism.[75]

Apparently hurt by the criticism of *Bambi*, Disney did accede to his critics' demands for more escapism in his own way, producing fantasy films between 1946 and 1959 that clearly demonstrated his conception of imagination as a mental place where audiences could vicariously experience the world as it should be. For Disney, the real world constantly disappointed because it failed to live up to the normative Victorian values he learned as a youth. By contrast, imagination was the space where those values could survive intact and flourish—a place of innocence and idealism. Similar to Wertham, Disney believed that a child's imagination required reassurance that the real world could be a wholesome, loving place that actually practiced what adults preached from their pulpits and podiums.[76] 1950's *Cinderella* and 1953's *Peter Pan*—films in which youngsters enter the adult world without sacrificing their ideals—certainly fit that bill, with some critics even panning Disney's post-war films for becoming mawkish and corny.[77]

Disney's confidence in both his conception of imagination and his film's capacity to feed it came from marketing data. In 1939, George Gallup set up the Audience Research Institute (ARI), providing movie studios with research into movie consumers' preferences and behaviour.[78] Between 1946 and 1957, Disney Studios made extensive use of the ARI's services, including studio screenings with test audiences and surveys.[79] In creating his post-war films, Disney relied on what pollsters gleaned, catering to what

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[75] Gabler, *Walt Disney*, 275, 415; Eisenstein, *Eisenstein on Disney*, 65–66.

[76] Gabler, *Walt Disney*, 275, 415; Wasko, *Understanding Disney*, 139.

[77] Gabler, *Walt Disney*, 200, 402, 415, 438, 442–43; Wasko, *Understanding Disney*, 113, 117–18, 125, 128.

[78] Susan L. Ohmer, "Measuring Desire: George Gallup and Audience Research in Hollywood," *Journal of Film and Video* 43 (1991): 8, 10.

[79] Ibid., 19, 23.

audiences liked most about his films. What they wanted was optimistic, escapist, and morally conventional content, confirming what Disney had suspected about imagination and how his films could best serve it.[80]

In creating that content, Disney sanitised the European fairy tales Wertham championed as the imagination's ideal fare. The classic versions of many fairy stories were violent, brutal and frightening, especially the Brothers Grimm retellings of German folklore. Their fairy tale universe abounds with torture, cruelty to children, frightening physical transformations, murder and cannibalism. Those medieval tales were cautionary ones created at a time when European families lived in closer quarters, experienced a more precarious existence, and could not shield children as much from death, disease, violence and sexuality.

Both Wertham and Disney believed that modern children should not be exposed to some of the most frightening aspects of the Brothers Grimm or Hans Christian Andersen.[81] But of the two men, Wertham was far more hopeful that if children did come into contact with the more horrific fairy tales, they would not be in the same danger as children who read comics. He was confident that some of the most troubling aspects of 'The Brave Little Tailor' or 'Hansel and Gretel' 'do not stimulate imitation in the everyday world so different from fairyland'. Wertham's confidence in children's immunity to that material was rooted in an assumption Bender shared. Both clinicians believed that modern children had a harder time suspending their disbelief when reading fairy tales set in enchanted forests with monsters and magicians. Given that fairy tale-settings would seem so obviously made-up to children, Wertham saw much less chance that they would imitate the misbehaviour depicted in those narratives.[82] Children could recognise that 'fairy tales…are unreal in a narrative sense, but real in a constructive ethical sense'.[83] Yet given what he had learned about his audience from the ARI data about what audience might consider objectionable, Disney was not willing to take any chances.

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[80] Wasko, *Understanding Disney*, 187, 209–12; Gabler, *Walt Disney*, 442–43.

[81] David Berland, "Disney and Freud: Walt Meets the Id," *Journal of Popular Culture* 15 (1982): 98–103; Fredric Wertham, *A Sign for Cain: An Exploration of Human Violence* (New York: Warner, 1969), 215; Wasko, *Understanding Disney*, 138–89; Tracey Mollet, "'With a Smile and a Song': Walt Disney and the Birth of the American Fairy Tale," *Marvels & Tales: Journal of Fairy-Tale Studies* 27 (2013): 109–24.

[82] Wertham, A *Sign for Cain*, 215.

[83] Wertham, untitled and undated written notes on an article regarding fairy tales [1956?], folder 16, box 40, Wertham Papers.

To create his sanitised on-screen fantasy worlds, Disney had his writers consult tamer versions of European fairy tales. Seventeenth-century French poet Charles Perrault 'systematically removed the disagreeable and disturbing aspects' of traditional folklore, crafting sanitised, moralistic fairy tales so as not to scandalise the nobles of Louis XIV's court. Not surprisingly Disney preferred Perrault to the Grimms, choosing the French poet's retellings as the basis for his film adaptations of *Snow White, Cinderella* and *Sleeping Beauty*.[84]

To depict those worlds on-screen, Disney's animators consulted approved visual references contained in the studio's Animation Research Library.[85] Its shelves contained prints of pre-Raphaelites, landscape painters and the European tradition of fantasy illustration Disney had been exposed to as a child reading storybooks.[86] For Disney, those books contained the quiet, pastoral dreamscapes where he mentally retreated from his abusive childhood in *fin-de-siecle* Missouri.[87] As an adult, he romanticised the small-town life of his youth, nostalgically elevating the rural to an ideal that offered virtue, goodness, comfort and natural beauty: imagination's optimal fuel.[88] His animators strove to create a similar cinematic universe of escape for Disney's audience, preferring British illustrator Arthur Rackham's Victorian drawings of gentle, childlike fairies to older depictions of menacing wee folk.[89] Its enchanted forests, glades and peasant hamlets evoke the Victorian association of the rustic, natural and old-fashioned with the Godly. Unsurprisingly,

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[84] Berland, "Disney and Freud," 99.

[85] Bruno Girveau, "Walt Disney at the Museum?," in *Once Upon a Time Walt Disney: The Sources of Inspiration for the Disney Studios*, ed. Bruno Girveau (New York: Prestel, 2008), 18, 22.

[86] Robin Allan, "Disney's European Sources," in *Once Upon a Time Walt Disney*, 100.

[87] Ibid., 101, 125, 186; Bruno Girveau, "Beyond the Mirror: Walt Disney and Literature and Cinema," in *Once Upon a Time Walt Disney*, 172–80; Avila, *Popular Culture in the Age of White Flight*, 120; Lella Smith, "The Collections and Origins of the Animation Research Library," in *Once Upon a Time Walt Disney*, 38; Gabler, *Walt Disney*, 18, 46, 312; Marc Eliot, *Walt Disney: Hollywood's Dark Prince* (New York: Birch lane, 1993), 7, 9, 10.

[88] Gabler, *Walt Disney*, 18–24.

[89] Allan, "Disney's European Sources," 100, 104, 106, 108, 110, 118, 134, 141–42, 144, 148, 156, 162, 166; Girveau, "Beyond the Mirror," 176, 178, 188, 190; Girveau, "Walt Disney at the Museum," 22, 24–28, 36; Smith, "The Collections and Origins of the Animation Research Library," 48.

Disney's beautifully rendered romanticisations of the rural past stand in contrast with the comics' hastily drawn stories of vigilantes battling urban thugs on mean streets.[90]

In his 1954 ABC television show *Disneyland*, his 1955 theme park of the same name, and his post-war feature films, Disney offered the all-ages mass culture that parents and critics hoped the comics could become after the Comics Code's creation. Both his films and his Anaheim tourist attraction offered a counter to the decadent urban culture represented by the comic books and older amusement parks such as Brooklyn's Coney Island. Comic books were not only published in Manhattan, their stories were often set there or in some fictive version of it. Wertham accused these urban crime comics of promoting lowbrow culture, violence, crude language, immorality and sexuality, while Disney levelled the same accusation at Coney Island.[91] Disney's films and Disneyland were middlebrow mass culture products devoid of those elements. As Disney remarked: 'There is enough ugliness and cynicism in the world without me adding to it'.[92] Wertham, a psychiatrist, could not have said it better.

Conclusion

Entering the 1950s, U.S. psychiatrists not only influenced how the public defined mental health, but they also identified risks to it. Even though imagination was never an object of formal medical treatment, Fredric Wertham and Lauretta Bender's assumptions about imagination became central to the debate over the mental health danger of mass consumer culture. While unorthodox within the psychological sciences, it was Wertham's conception of imagination as something pure and corruptible that resonated most with American consumers who not only supported the censorship of comic books, they also approved of the fantasies Walt Disney presented at the bijou.

Both Disney's films and the war on comic books found a receptive post-war audience because both helped feed the 'Greatest Generation's' desire to recreate an ideal America that had never been historical reality. I also contend that Wertham and Disney—rather than Bender—resonated

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[90] Avila, *Popular Culture in the Age of White Flight*.

[91] Ibid., 107, 118; Wasko, *Understanding Disney*, 22, 171–72.

[92] Girveau, "Beyond the Mirror," 205.

with families caught in the Cold War's nostalgia trap. These two men offered a vision of imagination's place in society that supported American expectations for adulthood and consumption. It was not just that Wertham understood the inner life of a child to be something essentially pure and innocent that needed more adult protection than Bender's brand of preventive psychiatry offered. What both Disney and Wertham offered was support for the widespread feeling that imagination craved certain kinds of old-fashioned fantasies. If properly nourished in childhood, imagination could help sustain an adult throughout his life. As Disney claimed: 'I do not make films primarily for children. Call the child innocence. The worst of us is not without innocence, although buried deeply it might be. In my own work, I try to reach and speak to that innocence'.[93] Wertham remarked that children's fantasy literature could even make an adult 'think of something bright and cheerful and idyllic'.[94]

What both Wertham and Disney tapped into was a sense that imagination was a natural resource Americans could domesticate and prune once childhood was over. Early Cold War rhetoric often intimated that the optimistic American imagination would ensure economic and scientific progress. But imagination required nourishment even in adulthood. By 1955, the popularity of Disney's products indicated that mass culture had become the primary site where adults expected to return to reassuring dream worlds. The success of the comic book censorship campaign demonstrates that they also expected the marketplace to help children develop those fantasies in the first place. In effect, the mid-1950s' comic book scare and Wertham's brand of preventive psychiatry should not be understood as a rejection of mass culture's influence over the self. Instead they should be understood as evidence of widespread acceptance of a mass-mediated subjectivity as a key condition of the US's post-war consumer model of citizenship.

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[93] Eliot, *Walt Disney*, vii.

[94] Wertham, "Reading for the Innocent," 1; Wertham, *Seduction of the Innocent*, 89–90.

CHAPTER 3

'They May Strike Back at Society in a Vengeful Manner': Preventing the Psychological Scars of Acne in Post-war America

Iain Ferguson

Introduction

In 2013, San Diego-based physician Dr. Richard M. Timms published a study entitled: 'Moderate acne as a potential barrier to social relationships: Myth or reality'. Timms divided his 143 participants into two groups: one set were shown pictures of clear skinned models, while the other was shown photographs of models with facial acne. Asked to guess the age of the models and rate them on a scale of sixteen personality items, the volunteers shown the clear skinned models believed them to be both older and more mature than the models suffering from acne. Moreover, the participants claimed they were more likely to be friends with and attracted to those with clear skin. Timms concluded that 'moderate acne vulgaris could be a potential barrier to social relationships for

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Mental Health in Historical Perspective,
https://doi.org/10.1007/978-3-319-98699-9_3

young people not simply because of their social anxiety but because they may well be meeting with prejudice'.[1]

Concern about the psychological effects of acne first emerged in earnest after World War II. Although earlier physicians acknowledged that acne caused a great deal of anxiety and misery for sufferers, especially girls and women, post-war studies raised concerns over the potentially serious psychological, social and economic implications for teenage acne sufferers. As a distinct and influential youth culture developed after World War II, the medical establishment was faced with the challenge of meeting their complex medical and social needs. James Roswell Gallagher, the founder of adolescent medicine in the United States, encouraged both health professionals and parents to be more respectful of adolescents' wishes and refrain from treating them like children. When his teenage patients were unable to conform to the idealised white, healthy and blemish-free body, Gallagher argued that emotional disturbance could result. Treating acne effectively not only prevented facial scarring, but it also prevented the marring of the psyche. In both journal articles and health columns, post-war physicians urged adolescent sufferers and their parents to seek medical attention for their problematic skin before it was too late. For millions of American teens, the prevention of psychological distress was only skin deep.

The history of acne, though largely unwritten,[2] provides an excellent lens through which to understand both the development of adolescent medicine and rising concerns about youth mental health following the World War II. According to Heather Munro Prescott, adolescent medicine grew out of profound changes in theories about adolescence that emerged during the 1930s and 1940s. The first facility dedicated exclusively to the well-being of adolescents was the Boston Children's Hospital, founded by Roswell Gallagher in 1952. Prescott claims that Gallagher encouraged a radically different clinical approach to dealing with adolescents, which emphasised listening carefully to the complaints

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[1] Richard M. Timms, "Moderate Acne as a Potential Barrier to Social Relationships: Myth or Reality?," *Psychology, Health & Medicine* 18, no. 3 (July 2013): 5, https://doi.org/10.1080/13548506.2012.726363.

[2] Robert Grant, "The History of Acne," *Proceedings of the Royal Society of Medicine* 44, no. 8 (August 1951): 647–52.

of young patients—no matter how trivial.[3] In the post-war period, the increasing number of lecturers devoted to highlighting the problems posed by acne proved that important groups like the American School Health Association were beginning to take notice. In 1957, for instance, San Francisco-based physician Herbert Lawrence presented a paper on the topic that served to suggest acne could be both caused by emotional turmoil and exacerbated by it, therefore resulting in a vicious cycle.[4]

As Mark Jackson has demonstrated, emotional tension or stress became a source of great concern for medical specialists during the post-war period. Specifically, 'post-war communities struggled to come to terms with the consequences of economic depression, the rise of totalitarianism, and the human cost of concentration camps, mass starvation, and atomic warfare'.[5] In this climate of fear, medical professionals feared that rising levels of poor mental health would lead to an increase in psychosomatic disorders, and viewed skin disorders such as acne as a form of psychosomatic illness, exacerbated by psychological factors. In the United States, for example, the Health Examination Survey between the years of 1966 and 1970 published a special report detailing the range of skin conditions prevalent amongst 12 to 17 year olds. Aside from investigating how many adolescents suffered from the condition, they devoted a segment of the report to discussing the link between stress, nervousness and the onset of acne thus implying that there was also a psychosomatic element to the condition.[6]

This chapter begins by arguing that increased medical concern about acne was a consequence of the development of adolescent medicine and worries about the mental health of young Americans. It investigates medical conceptualisations of the psychological causes and effects of acne during the post-war period, demonstrating how the condition became

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[3] Heather Munro Prescott, *A Doctor of Their Own: The History of Adolescent Medicine* (Boston: Harvard University Press, 1998), 177.

[4] Herbert Lawrence, "Acne, The Complexion Problem of Young Adults," Thirty-First Annual Meeting of the American School Health Association (November 11–15, 1957), *Journal of School Health* 27, no. 6 (June 1957): 164–70, https://doi.org/10.1111/j.1746-1561.1957.tb00860.x.

[5] Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013), 141.

[6] Jean Roberts and Jacqueline P. Ludford, "Data from the National Health Survey, Skin Conditions of Youths 12–17 Years, United States," U.S. Department of Health, Education, and Welfare, 157, no. 11 (August 1976), 1.

linked to mental health problems in adolescents amid broader concerns about youth mental health, juvenile delinquency, sexual promiscuity and racial unrest. Finally, it considers the range of different treatments offered to adolescent acne sufferers that promised to lessen both the aesthetic and psychological impact of the condition.

Acne and the Birth of Adolescent Medicine

In 1956, an article entitled ‘Their Speciality is Teen-agers’ appeared in the magazine *Parents and Family Home Guide*. Its author, editor Vivian Cadden described how staff at the Adolescent Unit of The Children’s Hospital in Boston were wrestling with the ‘exasperating, illogical and senseless’ nature of teenage patient health. She explained how teenage girls suffering from a heavy cold would spend a day at the beach and not ‘give a hoot’ whether they came down with pneumonia. These same girls, however, would feign illness and ‘mope around’ to convince their parents to let them stay at home ‘all because she has developed a pimple on her nose’.[7]

Founded by paediatrician James Roswell Gallagher in 1951, the Adolescent Unit was the ‘first comprehensive medical section caring for patients 12 to 21 years of age’.[8] According to Gallagher, family physicians, paediatricians, parents and teachers were all required to treat ‘young people as adolescents, not as little children, not as adults; they are not little boys or little girls any more, and they are not adults yet: they are young people who are beginning to be adults’.[9] Until this simple fact was understood, Gallagher believed the adolescent would thus continue to be viewed as something of an ‘enigma’.[10]

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[7] Vivian Cadden, “Their Specialty Is Teen-Agers: This Account of What Is Being Found Out and Done for Teen-Agers at the Adolescent Unit of the Children’s Hospital in Boston is Full of Helpful Ideas for Parents Everywhere,” *Parents’ Magazine & Family Home Guide* 31 (July 1956): 83–86.

[8] Wolfgang Saxon, “James Roswell Gallagher, 92, Leader in Adolescent Medicine,” *The New York Times*, November 15, 1995, https://www.nytimes.com/1995/11/15/us/james-roswell-gallagher-92-leader-in-adolescent-medicine.html.

[9] Ibid.

[10] James Roswell Gallagher, “Various Aspects of Adolescence,” *The Journal of Paediatrics* 39, no. 5 (November 1951): 532.

Gallagher's patients were part of the baby boom generation who helped create a distinct youth culture in the United States during the 1950s. Representing a whole new consumer market for the pharmaceutical, music, film and fashion industries (amongst others) to exploit, baby boomers also had divergent physical, social and psychological needs. In Gallagher's studies evaluating the emotional problems facing American teens, anxieties about various forms of abnormality were pronounced:

> The adolescent who is not maturing as rapidly as his or her companions, the boy who is shorter or the girl who is taller or more obese than usual, not only dislikes being different, but may become emotionally disturbed, fearing that she will keep on getting taller or that he or she will never mature.[11]

From a young age, teenage patients would have been shown charts relating to the desired standard height and weight measurements which 'were compatible with normality'. Gallagher argued that adolescents were concerned about being classified as abnormal and visibly different. He warned that, as adults 'seem to prefer that others conform to the average', there was a general belief that being too fat or thin was undesirable—a belief that frequently rubbed off on adolescents.[12]

Gallagher's positive, empathetic approach to adolescent health soon filtered down to health professionals charged with treating acne. In 1931, Swiss dermatologist Bruno Bloch studied over two thousand girls and boys aged between 6 and 19 years for signs of acne. Finding comedones and seborrhoea (considered the early stage of the condition) in over 70% of the 4000 patients he examined, Bloch argued that the 'appearance and development of the lesions of acne paralleled the development of the signs of puberty, i.e., the growth of axillary and pubic hair, the appearance of the secondary sexual characteristics and the beginning of the menses in girls'.[13] Widely respected as a dermatologist

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[11] James Roswell Gallagher and Constance D. Gallagher, "Some Comments on Growth and Development in Adolescents," *Yale Journal of Biology and Medicine* 25, no. 5 (April 1953): 335.

[12] Ibid., 348.

[13] Bruno Bloch, "Metabolism, Endocrine Glands and Skin Diseases with Special Reference to Acne Vulgaris and Xanthoma," *The British Journal of Dermatology and Syphilis* 43, no. 2 (February 1931): 51–87.

and meticulous in his research, Bloch's study was thus said to have proven, once and for all, that acne was indeed nothing more than a normal reaction to the physiological changes taking place during puberty.[14] Although acne had been seen as merely a 'physiological manifestation of puberty' prior to the war, Gallagher's influence helped to change such dispassionate, resigned attitudes.[15] An article published in the *American Journal of Nursing* in 1950 signified the apparent shift in perception. In it, Margaret Reilly, based at the Massachusetts General Hospital of Nursing, expressed frustration at the lack of interest nurses and doctors expressed towards acne. In her experience, 'many adolescents had been dismayed by a causal "Oh it's your age; buck up and you will outgrow it!"', when consulting their general practitioner. Such sweeping statements were dangerous because they offered teenagers and their families false hope. Having had their fears allayed, acne sufferers would fail to seek medical expertise and irreversible skin damage would often ensue, characterised by deep pit marks and facial scarring. Reilly argued that acne undermined adolescents' desire to be socially accepted, with the result that many people exhibited 'an unreasonable fear of "catching" skin infections'.[16] Gallagher and his colleagues felt it necessary to 're-emphasise' some key points concerning how best to approach the skin ailment in 1956. The problem of acne was significant not only due to its ubiquity but also because of its potential impact on the sufferer's personality. As such acne management required an in-depth 'knowledge of the patient's personality' as well as the relevant medical literature. Physicians should also maintain a genuine interest in the patient's extracurricular

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[14] Ibid.

[15] Lester Hollander, "The Role of Endocrine Glands in the Etiology and Treatment of Acne," *Archives of Dermatology and Syphilology* 3, no. 5 (March 1921): 593, https://doi.org/10.1001/archderm.1921.02350180017002. Although pre-war studies examined the role the endocrine glands, dietary influences and bacteria played in causing acne, an increasing number of studies in the post-war period investigated whether acne could be caused by emotional turmoil and/or exacerbated by it, therefore resulting in a vicious cycle. In 1951, for example, consultant psychiatrist with the Skin Department at St Bartholomew's Hospital, London, Dr. Eric Wittkower, enrolled sixty-four patients with acne in a psychosomatic study in order to find if there was a correlation between emotional disturbances and the onset of acne. Eric Wittkower, *British Journal of Dermatology* 63, no. 6 (June 1951): 214–33, https://doi.org/10.1111/j.1365-2133.1951.tb13715.

[16] Margaret Reilly, "Juvenile Acne," *American Journal of Nursing* 50, no. 5 (May 1951): 269.

activities in order to establish a trusting relationship. Establishing this relationship was vital for enabling the patient to discuss not only his/her skin problems, but also his/her concerns for the future and, in due course, accepting and following the physicians' treatment. Physicians were advised to see the patient on their own, away from their parents—who hindered their ability to understand the 'whole personality of the patient'.[17]

Shortly after the publication of this paper, the problem of acne amongst students gained the attention of members from the American School Health Association. In 1957, San Francisco-based physician Herbert Lawrence presented a paper entitled 'Acne, The Complexion Problem of Young Adults' at the Thirty-First Annual Meeting of the American School Health Association.[18] Held in the luxury Hotel Hollenden, Cleveland, Ohio, the meeting was borne out of the American Progressive Health Reform Movement's desire to improve the health of American children. Although Lawrence outlined the current scientific understandings regarding the cause of acne, he personally felt that the pursuit of finding one singular source of adolescent acne was fruitless. Given the numerous changes to their bodies, their behaviour patterns and the onset of emotional conflicts regarding 'dependency, independency and sexuality', Lawrence proposed looking at the whole adolescent acne patient, rather than any specific factor. This indicated that physicians were beginning to consider alternative theories relating to how to understand and treat adolescent acne sufferers. Lawrence reminded his audience that the teenage years were 'an exceedingly active time for these young people'; all his patients had hectic lifestyles. Aside from the demands that came with having a demanding school schedule, teenagers were also involved in extracurricular activities, and some had part-time jobs to pay for their newfound social life.

Moreover, Lawrence proposed a theory connecting emotional turmoil and acne. As overactivity of the oil glands was thought to contribute to patients' outbreaks, Lawrence referenced unnamed studies in which

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[17] James Roswell Gallagher, Robert Masland, Felix Pierpont Heald, and William Robert Hill, "Some Comments on Acne Vulgaris in Adolescents," *The Journal of Pediatrics* 49, no. 6 (December 1956): 680.

[18] Herbert Lawrence, "Acne, The Complexion Problem of Young Adults," Thirty-First Annual Meeting of the American School Health Association (November 11–15, 1957), *Journal of School Health* 27, no. 6 (June 1957): 164–70.

adolescents were placed under enormous stress by psychiatrists and psychologists who determined the levels of oil secreted before and after the test. Findings from the tests showed that adolescent patients secreted ‘an abnormal amount of oil under stress’. In one study, a group of teenage patients were recruited to carry a journal for three months, noting ‘the number of acne lesions that they had each day and note episodes of emotional tranquillity or lack of it throughout this period’. Lawrence considered the physiological basis for this phenomenon:

> There is a theory that during stress the oil gland secretion is accelerated. During periods of quiescence the oil is stagnant in the follicle, hardens and forms a plug. When another period of stress comes along, the plug prevents the secretion from reaching the surface of the skin and produces an irritating impaction or foreign body in the follicle or its opening. This in turn sets up the whole inflammatory process which results in the clinical lesions of acne.[19]

Lawrence’s concerns about the negative consequences of acne were echoed by the American National Centre for Health Statistics. In the United States, the National Centre for Health Statistics sponsored the Health Examination Survey between the years of 1966 and 1970 in order to ‘determine the health status of the population’.[20] As the survey during this period explicitly focussed on the range of health conditions affecting adolescents between the ages of 12 and 17, a special report detailing the range of skin conditions prevalent within this group was produced from the resulting data. While the data were ‘based on direct examination findings from the Health Examination Survey of 1966–1970 among a national probability sample representative of the 22.7 million youths’ residing in America during this period, the data from sources such as patient questionnaires, medical histories and physical examination found acne to have a seriously detrimental impact on adolescents during a critical period in their development. Using the probability sample of youth in the Health Examination Survey of 1966–1970, it was found that only 27.7% of youths between the ages of 12 and 17 could be characterised as having normal skin and no signs

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[19] Ibid., 168.

[20] Roberts and Ludford, “Data from the National Health Survey, Skin Conditions of Youths 12–17 Years,” 1.

of acne or facial scarring. Moreover, it was claimed that 15.5 million youths suffered from facial acne—68% proportion of the population. As facial acne was identified as the 'most frequently occurring of the skin conditions' amongst 12- to 17-year olds, acne was said to be 'slightly more prevalent amongst girls (69.8 per 100) as opposed to teenage boys (66.4 per 100)'.[21] Nearly 85% of youths who suffered from acne admitted to their condition bothering them. Arguably telling of the medical professions' increasing belief of the role played by stress to the onset of acne, the report dedicated a segment to discussing the relation of stress and other health habits to the severity of the condition. Within the survey, the authors argued that there was a definite association between the 'degree of nervousness (youth's rating) and the prevalence of acne' amongst white youths. For the youths who attested to being 'never' or 'rarely' nervous (62.6 per 100) the rates of acne were 'statistically significant' when compared with those who identified with being 'often' or 'very' nervous (77.0 per 100). Moreover, acne was said to be 'slightly higher' amongst youths who were said to be 'seriously maladjusted in school'—the findings thus implying that the condition was more pronounced in adolescents found to be emotionally disturbed.[22]

While the increasing concern about acne paralleled the rise of adolescent medicine and the anxieties over the mental health of young Americans, the findings that the condition could be both caused and exacerbated by emotional turmoil requires one to investigate the reasons why the prospect of suffering from acne caused doctors to believe that acne caused teenagers such high levels of anxiety. During the post-war period, doctors, dermatologists, criminologists and sociologists ultimately served to construct acne as being a threat to not only one's social standing but also, equally, the social order of the United States.

The Social Repercussions of Acne

Medical concerns about the psychological scars of acne were magnified by the media. Stanley Cohen's seminal publication *Folk Devils and Moral Panics* (1972) helped to establish the media's role in creating moral

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[21] Ibid., 2.

[22] Ibid., 13. For more on the psychosomatic aspects of acne in the post-war period, see Eric Wittkower, "Acne Vulgaris: A Psychosomatic Study," *British Journal of Dermatology* 63, no. 6 (June 1951): 214–23, https://doi.org/10.1111/j.1365-2133.1951.tb13715.x.

panics. According to Cohen, periodically ‘a condition, episode, person or a group of persons emerges to become defined as a threat to societal values and interests; its nature being presented in a stylised and stereotypical fashion by the mass media’.[23] Considering the mass media’s influence in spreading fear and panic amongst the public with regards to the outbreak of the AIDS virus sociologist Kenneth Thompson has argued that ‘an important consideration is the way in which a succession of illnesses are given a moralistic meaning that stigmatizes the victim as a pariah or social deviant. This moralizing process is increasingly accomplished through representations in the mass media’.[24] Although on a much smaller scale to the moral panics created about AIDS, acne, too, was constructed as a real threat to the social order. In 1958, for example, during one of his syndicated ‘Worry Clinic’ columns, psychologist and physician George W. Crane warned how high-school student acne sufferers:

> may strike back at society in a vengeful manner, figuring they got a raw deal. In the latter case, many juvenile delinquents are violating laws and causing trouble for our faithful policemen, just because those kids have pimply complexions. For a lot of crime is based on an attempt by scarred patients to compensate psychologically for their imagined ostracism by society.[25]

So, why were teens seen as a threat to the American moral fabric? According to journalist Ann Anderson, ‘newspapers exaggerated the threat of juvenile delinquency [teenage crime rates in the 1950s were actually fairly low] and cops treated first time offenders like hardened felons because they were everything adults feared about the new teenage culture’.[26] The link between acne and anti-social behaviour mirrored earlier infamous connections between physiognomy and criminality, not least the

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[23] Stanley Cohen, *Folk Devils and Moral Panics* (London: Routledge, 1972), 9. For more on how society has historically feared and reacted to those who with visible signs of illness and disability, see: Sander Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (New York, Cornell University Press, 1988).

[24] Kenneth Thompson, *Moral Panics* (London: Routledge, 1998), 70.

[25] George W. Crane, “The Worry Clinic: Help Is Sought By Girl with Acne,” *Lakeland Ledger* (March 26, 1958): 3.

[26] Ann Anderson, *High School Prom: Marketing, Morals and the American Teen* (London: McFarland & Co, 2012), 38.

work of Italian physician Cesare Lombroso.[27] Lombroso theorised that criminals were recognisable by certain physical traits and defects which distinguished them from normal, law abiding citizens. Influenced by Charles Darwin's theory of evolution, Lombroso believed that criminals 'exhibited numerous anomalies in the face, skeleton, and various psychic and sensitive functions, that they strongly resembled primitive races'.[28]

Sociological and criminological studies backed up the media's interest in the physical characteristics of the archetypal juvenile criminal. In one study investigating physical disfigurement and juvenile delinquency, criminal psychopathologist Ralph S. Banay claimed the present type of juvenile criminal was a 'shy youngster with a slight physical defect: a nose that's too big, eyes of two different colours, crossed eyes, acne, a disfiguring birthmark, or a club foot'. Such physical deformities had the potential to lead to criminal acts such as burglary, fraud or even murder. Specifically, in 1943, Banay highlighted the murder of a well-known executive. The murderer was a 15-year-old boy severely disfigured by acne. As a result of his disfigurement, he refused to see anyone preferring to sleep during the day and walk the streets at night, his deformities hidden under the cover of darkness. Friendless and lacking employment, he supported himself financially by engaging in a series of armed robberies one of which turned deadly. Upon threatening his victim with a gun, the boy was surprised to come up against stern resistance. In a state of panic, the boy shot the victim dead. He was soon caught and executed for his crime. In another case, Banay discussed 'an eighteen-year-old boy with a pock-marked face'—who descended into a life of crime. When the boy was 15, he suffered from an attack of chicken pox, resulting in permanent scarring. Mistaking the outbreak for a flare up of acne that would eventually clear up, he moved to New York to enrol in the Coast Guard only to be turned down and told by the head of city employment services that 'no employer would hire a man whose face would only repulse customers and co-workers'—a revelation which lead to him committing armed robberies on several grocery stores.[29]

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[27] Gina Lombroso and Cesare Lombroso, *Criminal Man: According to the Classification of Cesare Lombroso* (New York: Putnum, 1911), 3.

[28] Imogene Moyer, *Criminological Theories: Traditional and Non-traditional Voices and Themes* (London: Sage, 2001), 32.

[29] Ralph S. Banay, "Physical Disfigurement as a Factor in Delinquency and Crime," *Federal Probation Journal* 7, no. 1 (June 1943): 21.

The efforts of sociologist Frances Cooke Macgregor also highlighted the social and psychological ramifications of facial deformities after the World War II. In recent years, Macgregor has been credited ‘as the first scholar to document the major social and psychological stresses of patients who suffer facial disfigurement through birth, accident, disease or war’.[30] In 1951 Macgregor published a paper describing some of the psychosocial problems experienced by people with facial deformities. Macgregor claimed that people with diseased or scarred faces often faced the stereotype that they had led an immoral life. Frequently ridiculed and avoided, they risked becoming social outcasts. ‘Physical handicaps’, such as acne, a twisted nose or facial scarring essentially acted as barriers to the privileges and opportunities enjoyed by the unscarred.[31]

The problem of acne continued to be a source of anxiety for health professionals in the 1960s. Dr. Lilis F. Altschuler of the University of Cincinnati College of Medicine echoed many of George W. Crane’s earlier findings when he claimed that antisocial behaviour could indeed be traced to acne. In Altschuler’s experience working with offenders at the Cincinnati Juvenile Court, it was found that acne contributed to truancy, antisocial behaviour and sexual delinquency. Altschuler explained how dealing with juvenile offenders who suffered from physical defects, including acne, required ‘a team approach involving other agencies of the court’. Discussing the case of a 15-year-old boy referred to the court for shoplifting and truancy, the team concluded that his failure to attend school regularly was likely due to his severe acne. In another case, the inappropriate sexual behaviour of a 15-year-old girl was blamed on her anxiety and feelings of inferiority regarding her poor skin condition. After successful treatment, both adolescents’ poor behaviour markedly improved. Altschuler happily reported that the young man attended school more regularly and the girl graduated, later holding down a responsible job. In describing the girl’s delinquent behaviour, it is noteworthy that Altschuler proposed a causal link between her promiscuous behaviour and the onset of her acne.[32] During this period, many teenage

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[30] Myrna Oliver, “Frances Macgregor, 95; Social Scientist,” *Los Angeles Times*, February 8, 2002, http://articles.latimes.com/2002/feb/08/local/me-frances8.

[31] Frances Cooke Macgregor, “Some Psycho-social Problems Associated with Facial Deformities,” *American Sociological Review* 16, no. 5 (October 1951): 629–38.

[32] Lilis F. Altschuler, “Antisocial Behaviour Traced To Acne,” *Bastrop Advertiser and Bastrop County News* (October 24, 1968): 12.

boys and girls were said to have 'rejected traditional standards of sexual morality that forbade sex outside of marriage, and embraced the "sexual revolution"—the popular movement that equated sexual freedom with personal liberation'.[33] Despite there being a notable shift in youth attitudes towards sex in the late 1960s, Altschuler's fears about acne promiscuity echoed post-war anxieties about youth culture and sex.[34]

The opening of several American acne clinics also signified that the medical establishment took the condition seriously. Although the majority of acne clinics set up offered treatment to white, American adolescents, there were exceptions. In the 1950s, cosmetic surgeon Harold E. Pierce set up the 'West Park Clinic in West Philadelphia, a dermatological practice that focused on African Americans'.[35] Pierce spoke of the dermatologist's practice as being a 'luxury', with the majority of the 3500 dermatologists in the United States located in highly developed and largely white urbanised areas. Pierce lamented the ease with which white teenagers, suffering from acne or other dermatological complaints, could locate a dermatologist and be seen straight away, compared to the plight of African-American youth:

> The white teen-ager, armed with his parents' check book, by scouting around, can generally locate a dermatologist who will arrange an appointment for this patient right after school. Within a short time, his or her teen-age acne is controlled to the point of social acceptance and everyone is happy.[36]

Acknowledging the socio-economic disparities between the two groups, Pierce argued that there was a 'dermatological gap which penalised black youth'. Setting up a bi-weekly Teenage Acne Clinic at the West Park Clinic, Pierce and his staff focussed on helping black youth combat their complexion problems. By doing so, they hoped the scheme would thus help reduce

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[33] Carolyn Bronstein, *Battling Pornography: The American Feminist Anti-pornography Movement, 1976–1986* (Cambridge: Cambridge University Press, 2011), 25.

[34] Patrick Jamieson and Daniel Romer, *The Changing Portrayal of Adolescents in the Media Since 1950* (Oxford: Oxford University Press, 2008), 43.

[35] Gayle Sims Ronan, "Harold E. Pierce Jr., 84, Dermatologist, Surgeon," Philly.com (November 4, 2006), http://articles.philly.com/2006-11-04/news/25406168_1_dermatology-medical-degree-surgeon, accessed 10 September 2016.

[36] Harold E. Pierce, "Dermatologic Involvement with Black Youth," *Journal of the National Medical Association* 63, no. 1 (January 1971): 58.

their hostility to the largely white medical profession by showing the youngsters that someone from outside their family circle cared about them and their dermatological problems. Pierce claimed that the Acne Clinic was determined to 'reinforce the idea that indeed, "Black is Beautiful"'.[37] Black youths attending the clinic were assigned individual appointments, where they were examined and treated according to their personal requirements. Not only were they given detailed educational material to help them understand the 'intricacies of teenage acne', but they also received the chance to compare notes with other acne sufferers and discuss their progress in a relaxed environment. Pierce ensured that the West Park Clinic offered their services (including both consultations, and treatments and medications) free of charge to their 1500 black patients. The dermatologist argued that if more resources were assigned to treating black teenagers' dermatological complaints, then a 'morale-uplifting capability value would be the result'. If dermatologists were equally willing to treat acne in black teens, it would help to reduce black drop-out rates, juvenile delinquency and hostility. Pierce believed that showing black teenagers that the medical profession cared could even contribute to reducing the number of black gang deaths in Philadelphia. Such claims underlined how well established the link between acne and both individual and societal turmoil was by the 1960s. As the final section of the chapter demonstrates, the pharmaceutical industry was quick to take advantage of these concerns.

Treating the Tormented

A plethora of treatments were available by the 1950s which offered the hope of both clear skin and psychic succour to the acne sufferer. While advertisements for anti-acne creams like Clearasil hinted at the moral connotations of having an acne-free complexion, physicians also offered tranquilisers, anti-depressants and, in some instances, hypnotherapy to treat depressed acne sufferers. Dermatologists went as far as to offer surgical procedures such as dermabrasion therapy and dangerous chemical peels to minimise the facial scarring often blamed for causing such mental anguish amongst the adolescent population.

In the decades following the World War II, the pharmaceutical industry invested heavily in drug development for a host of conditions. These drugs included anti-inflammatories such as corticosteroids,

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[37] Ibid., 59.

cardiovascular drugs, psychoactive drugs, chemotherapy for cancer and new antibiotics.[38] In dermatology, numerous drug therapies such as antibiotics, topical corticosteroids and the highly toxic methotrexate (usually used to treat psoriasis) were used to treat acne.[39] Introduced by American inventor Ivan Combe in 1951, the acne cream Clearasil frequently represented the condition as a threat to teens' popularity and their chances of finding a romantic partner. In their 'Clearasil Personality of the Month' advertising campaign, for instance, the advertisements featured both male and female teenage acne sufferers who had adopted Clearasil as their treatment of choice and were only too happy to tell the world about its miraculous benefits for their physical and emotional health as well as their social lives. For instance, the 1957 November edition of *Boy's Life* featured 'popular' John O'Ryan who explained how Clearasil had taken care of his 'complexion problems':

> For years I had trouble with pimples. I tried many other medications but nothing really worked until I hit on Clearasil. In just a short while with Clearasil my face started clearing. Now I'm no longer embarrassed by complexion problems.[40]

For dermatologists, psychological factors could also play a role in the onset and subsequent exacerbations of skin. During a discussion concerning the relationship between 'psychiatry and the skin' in 1950, for example, dermatologist Robert W. Mackenna described the 'two diametrically opposed beliefs concerning the relationship of the mind and the body in the etiology of skin diseases'. As the following extract demonstrates, the rhetoric employed by Mackenna also reinforced the gendered norms and ideals of the era where acne was portrayed as both having the potential to ruin girls' self-confidence and as a threat to a girl's femininity:

> Whilst the unsightliness of acne vulgaris – or of the scars left by the lesions – may greatly interfere with a girl's self-confidence and gravely affect her

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[38] George C. Andrews, Anthony C. Domonkos, and Charles F. Post, "Treatment of Acne Vulgaris," *Journal of the American Medical Association* 146, no. 12 (July 1951): 1107–13, https://doi.org/10.1001/jama.1951.03670120017005.

[39] Gordon Mitchell-Heggs, "Drugs in the Treatment of Acne Vulgaris," *British Medical Journal* 2, no. 5162 (December 1959): 1320–22.

[40] "Clearasil Personality of the Month" advert, *Boys' Life* (November 15, 1957): 77.

> attitude to the social problems of her life so that she may become a recluse, or – thinking that acne is a visible sign of masculinity – may become as aggressive and as masculine as she can make herself, prolonging a state of unstable psychological equilibrium which may eventually lead to a breakdown.[41]

Excoriated acne, whereby sufferers picked compulsively at their blemishes, exacerbating scarring, had been researched by dermatologists William Allen Pusey and Francis E. Senear during the early twentieth century, but little attention had been paid to the issue since 1920.[42] In 1954, Canadian physician Norman M. Wrong used the *Archives of Dermatology and Syphilology* to express his displeasure concerning the lack of attention paid to the problem of excoriated acne in young women during the post-war period.[43] Despite the availability of information about excoriated acne in British and American dermatology textbooks, Wrong argued 'that excoriated acne of females is more common than is usually supposed, that its lack of recognition often results in inadequate treatment, and that such inadequate treatment causes needless mental upset to the patient and persistence of the eruption for years'.[44] Wrong found that the problem was not reserved to one specific age group but was rather similar between females aged between 16 (16 being the youngest recorded case) and 40 (being the oldest) years of age. Therefore, Wrong urged that his colleagues refrain from thinking of excoriated acne as being solely a problem of young girls and consider it more as an issue that affected women in general. Adding his own contribution to previous observers' thoughts on the defining characteristics of females who suffered from excoriated acne, Wrong divided patients into the following three groups: (a) slightly masculine type, (b) vain type of girl who thinks of nothing but her appearance and spends hours each day in front of her mirror, and (c) good-looking type of girl who does not

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[41] Robert MacKenna, "Discussion: Psychiatry and the Skin," *Proceedings of the Royal Society of Medicine* 43, no. 797 (April 1950): 797–803.

[42] William Allen Pusey and Francis E. Senear, "Neurotic Excoriations with Report of Cases," *Archives of Dermatology and Syphilology* 1, no. 3 (March 1920): 270–78, https://doi.org/10.1001/archderm.1920.02350030038003.

[43] Norman M. Wrong, "Excoriated Acne in Young Females," *Archives of Dermatology and Syphilology* 70, no. 5 (November 1954): 576–82, https://doi.org/10.1001/archderm.1954.01540230026003.

[44] Ibid., 576.

have as much attention from the opposite sex as she feels is her due and who blames the real or imaginary blemishes on her face for this lack of attention. During his consultations with sufferers, Wrong claimed he saw many patients with brownish stains and superficial scars 'which suggested to him that the patient was picking the lesions on her face'. If confronted by the physician, Wrong suggested that, often, they would freely admit to doing so and communicate the reason behind their destructive actions. While the reasons varied, the most frequent reasons cited tended to be anxiety relating to school exams, exhaustion, difficulties at home or in the workplace and ongoing problems with their partners.

Although the root causes of excoriated acne were often psychological, physicians often turned to pharmacological solutions to control it.[45] San Antonio physician Dr. James Lewis Pipkin claimed that treating 'pickers' with the sedative phenobarbital often helped break the vicious cycle of picking and scratching their faces.[46] In other skin conditions, where there was an 'uncontrollable urge to scratch or in whom a tension factor contributed to the cutaneous disorder', dermatologists embraced the new tranquilliser drugs which had been developed in the aftermath of the war. Drugs such as Ethchlorvynol (marketed as Placidyl), Meprobamate (Miltown) and Perphenazine (Trilafon) were used to treat the emotional disturbances linked with skin disorders like atopic dermatitis, contact dermatitis and lichen planus (amongst many others).[47] While some of these treatments

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[45] Ibid., 576–82.

[46] James Lewis Pipkin, "Treatment of Acne Vulgaris," *Medical Clinics of North America* 49, no. 4 (July 1965): 1–18.

[47] In the majority of studies, the authors claimed that both dermatologists and psychiatrists prescribed tranquilliser drugs: 'because certain dermatological syndromes have so frequently appeared closely bound up with emotional factors, the use of sedatives as an adjunct therapy has become widespread in these conditions'. Oscar Sokoloff, "Meprobamate (Miltown) as Adjunct in Treatment of Anogenital Pruritus," *American Medical Association Archives of Dermatology* 74, no. 4 (October 1956): 393, https://doi.org/10.1001/archderm.1956.01550100061012. For other examples of tranquillisers being used to treat skin disorders, see: Charles R. Rein and Raul Fleischmajer, "The Tranquilizing Efficacy of Ethchlorvynol (Placidyl) in Dermatological Therapy," *American Medical Association Archives of Dermatology* 75, no. 3 (March 1957): 438, https://doi.org/10.1001/archderm.1957.01550150126019; Jay Shanon, "A Dermatologic and Psychiatric Study of Perphenazine (Trilafon) in Dermatology," *American Medical Association Archives of Dermatology* 77, no. 1 (January 1958): 119, https://doi.org/10.1001/archderm.1958.01560010121024; James G. MacLean, "Treatment of Acne with Prothipendyl," *Canadian Medical Association Journal* 84, no. 8 (February 1961): 427–30.

calmed patients, side effects of the sedatives included ‘dopiness’, ‘dullness of perception’ and palpations (amongst others).[48]

Other physicians sought drug-free alternatives. In medicine, hypnosis has long been used to alleviate dermatological problems.[49] In 1958, for instance, Johns Hopkins University dermatologist Mark B. Hollander presented a paper describing the use of post-hypnotic suggestion to control the excoriated acne. The paper, presented at the First Annual Meeting of The American Society of Clinical Hypnosis, described acne as being a ‘profoundly traumatic experience to its victims, especially in adolescence when the developing individual first becomes aware of the opposite sex’.[50] Hollander explained that some patients ‘retaliated by attacking the acne directly, trying to press out and thus get rid of the offending blackheads and pimples’. With their actions often resulting in a worsening of their skin, Hollander noted that well-meaning parents would constantly badger their offspring to refrain from picking their faces. Along with having to deal with overbearing parents, some patients would also be targeted by bullies. Hollander explained that pressure from parents and worrying about bullies only served to increase patient anxieties. Patients would become incapacitated by feelings of guilt and, what initially began as an effort to rid their face of pimples quickly became a device for punishing oneself compulsively. Hollander acknowledged that coping with such patients was challenging and noted that, ‘at this point, he has his hands full’. Treating the initial outbreak of acne was impractical as the patients had to firstly be persuaded to stop picking their skin—something which they were often reluctant or incapable of doing. When the initial outbreak of acne was successfully treated, pitted scars and blood crusts, from picking, marred the complexion of patients. Hollander explained how, after 5 weeks of intensive treatment, the pimples of a 19-year-old college student had disappeared. During a follow-up appointment, however, he noted blood-crusted excoriations on her face caused by picking. He then employed post-hypnotic suggestion:

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[48] Sokoloff, “Meprobamate,” 393.

[49] Philip D. Shenefelt, “Hypnosis in Dermatology,” *American Medical Association Archives of Dermatology* 136, no. 3 (March 2000): 393–99.

[50] Mark B. Hollander, “Excoriated Acne Controlled by Post-hypnotic Suggestion,” *American Journal of Clinical Hypnosis* 1, no. 3 (July 1959): 122.

> She went into a somnambulistic trance readily, and was told that when she wanted to pick her face she was to remember the word 'scar'. This word was to symbolise the effects of picking on her face and her appearance. Since she did not want to spoil her appearance, she would be able to refrain from picking merely by saying 'scar'. One week later there has been no picking, and the face was smooth. The suggestion was reinforced on three occasions in late March and late April. In mid-May, there has been occasional picking, but no excoriations or crusts could be seen and the patients felt that she was under good control. This remained true in September.[51]

While hypnosis worked for some people, acne sufferers who had been left scarred by the condition also sought surgical procedures to reduce both their dermatological damage and their emotional suffering. Included amongst the possible solutions was cosmetic surgery. Although being left scarred by acne posed little threat to patients' physical health, it was the detrimental impact the disfigurement would have on their emotional well-being that helped dermatologists to justify such procedures. Scholars have claimed that 'cosmetic surgery acted as a kind of psychotherapy that made an intervention into the body for the purposes of dealing with psychic trauma or distress'.[52] In the early twentieth century, German dermatologist Ernst Kromayer introduced an abrasion technique to reduce the scars left behind by a host of skin diseases and defects. Using dental burrs fixed to a motor-driven powered dental drill, Kromayer's new innovation proved valuable in treating and removing skin imperfections such as freckles, pitted scars and keloids.[53] Taking inspiration from Kroymayer's work, subsequent dermatologists introduced their own abrasion methods for treating acne scars and other skin deficiencies in the late 1940s and early 1950s. In 1947, American plastic surgeon Preston C. Iverson presented a paper to the Philadelphia Academy of Surgery detailing the use of sandpaper in minimising the scars often left behind by both acne and traumatic tattoos. Marked by 'its seemingly brutal treatment of skin

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[51] Ibid.

[52] Sheila L. Cavanagh, Angela Failler, and Rachel Alpha Johnston Hurst, *Skin, Culture and Psychoanalysis* (London: Palgrave Macmillan, 2013), 129.

[53] Frederick Reiss, "Kromayer Method of Corrective Surgical Planning of Skin," *Archives of Dermatology and Syphilology* 69, no. 6 (June 1954): 744–46, https://doi.org/10.1001/archderm.1954.01540180094016.

tissues', Iverson nevertheless believed his method was worthwhile. Not only would using sandpaper reduce the severity of facial scars left behind by acne and traumatic tattoos, but it was believed the technique would help reduce the embarrassment felt by sufferers.[54]

Some dermatologists, however, expressed concern that those inexperienced with the technique might go too far and produce what amounted to a third-degree burn and irreversible facial scars.[55] In order to unearth safer and more enhanced surgical means for reducing acne scars, New York-based dermatologist Abner Kurtin designed his own technique which became known as dermabrasion therapy.[56] Not only did Kurtin's procedure revolutionise dermatological surgery, but it also lead to skin specialists being able to perform skin-corrective surgeries in an office-based setting.[57] Some skin specialists believed it was necessary to evaluate acne sufferers' emotional state before offering them dermabrasion therapy. Adolph Brown, a Beverly Hills-based dermatologist, for instance, reminded his colleagues to consider their patients' motivations. In Brown's view, acne sufferers could be separated into three classes of people: 'Well-adjusted persons, persons with inadequate personalities, and psychotic or pre-psychotic persons'. Brown felt the reasoning of the well-adjusted for dermabrasion was straightforward; they wanted it for 'purely cosmetic purposes' and hoped it would provide them with the social and economic advantages that were associated with having a clear complexion. It was believed such 'well-adjusted' patients were ideal candidates for the procedure as they had a 'clear insight into their problems and were obviously robust and emotionally healthy'. For the people considered to have 'inadequate personalities', Brown claimed that these patients retreated 'behind their facial handicap and blamed

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[54] Preston C. Iverson, "Surgical Removal of Traumatic Tattoos of the Face," *Plastic and Reconstructive Surgery* 2, no. 5 (September 1947): 427–32.

[55] William G. McEvit, "Treatment of Acne Pits by Abrasion with Sandpaper," *Journal of the American Medical Association* 142, no. 9 (March 1950): 647–48, https://doi.org/10.1001/jama.1950.72910270001008.

[56] Abner Kurtin, "Corrective Surgical Planning of Skin: New Technique for Treatment of Acne Scars and Other Skin Defects," *Archives of Dermatology and Syphilology* 68, no. 4 (April 1953): 389–97, https://doi.org/10.1001/archderm.1953.01540100029005.

[57] Noel Robbins, "Dr. Abner Kurtin, Father of Ambulatory Dermabrasion," *The Journal of Dermatologic Surgery and Oncology* 14, no. 4 (April 1988): 351–458, https://doi.org/10.1111/j.1524-4725.1988.tb03376.x.

all their inadequacies and dissatisfactions on it'. If the treating physician expressed concern for some of these patients and they improved aesthetically after treatment, however, Brown believed that their emotional well-being would improve as a result. Brown argued that the pre-psychotic or psychotic sufferers used their 'acne scars as rationalisation for all their personality, social and economic difficulties, giving the scars an importance completely out of proportion to the disfigurement'. Although Brown doubted such patients could ever be cured of their psychological problems (due to these type of people frequently finding another ailment to blame their perceived inadequacies on), he did concede that, if 'great care' was used when treating a selection of these patients then emotional improvement was not impossible.[58]

American dermatologists offered alternative procedures for minimising the facial scars left by acne. Procedures such as cryotherapy and phenol-based chemical peels were thought to be cost-effective, to reduce scarring and to improve mental well-being. However, as with many of the other surgical procedures offered to acne sufferers, those who administered the treatments were often untrained 'laymen' ignorant of the risks such solutions posed to patients' health.[59] The 1973 case of 21-year-old Canadian nurse Antoinette Cere was particularly harrowing. Cere had visited the Yolandre Peau de Soie Skin Clinic in Montreal looking for help in overcoming her stubborn case of acne. Paying the clinic $800, she was treated with a chemical peeling solution which contained resorcinol, lactic acid and salicylic acid. Once the chemical peel had been applied, Cere's face was covered with adhesive tape for 48 hours. Shortly after the treatment, Cere complained of feeling unwell, collapsed and died as a result of breathing failure. She was found to have suffered second-degree burns to her face and neck. During the coroner's inquest, it was found that the skin clinic did not have a license to carry out chemical peels and was only permitted to sell cosmetic

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[58] Adolph Brown, "Dermabrasive Ablation of Acne Scars," *California Medical Journal* 89, no. 2 (August 1958): 123–26.

[59] While it is beyond the scope of this paper to detail specific examples where acne sufferers have been seriously injured pursuing said mentioned treatments, for specific example case studies, see: Adolph Brown, Leo M. Kaplan, and Marthe E. Brown, "Phenol-Induced Histological Skin Changes: Hazards, Technique, and Uses," *British Journal of Plastic Surgery* 13, no. 3 (May 1960): 158–69, https://doi.org/10.1016/S0007-1226(60)80032-X; and Frank Mackey, "Death Linked to Skin Treatment," *The Montreal Gazette* (June 6, 1974): 8.

products.[60] As the permit to sell beauty products was only temporary, the clinic's co-owners, Yolande and Andre Marois, were accused of running 'an illegal operation'. Moreover, in his testimony, Andre Marois admitted that 12 of the 15 diploma certificates that hung on the clinic walls were fake; Marois admitted to having had them made due to his wife feeling 'ill at ease with having only three diplomas while others had many more'. In the aftermath of Cere's death, the pathologist who carried out the autopsy, Dr. Wesner Thesee, was quoted as saying:

> I am 100 per cent certain that if Miss Cere had not taken this treatment she would be alive today. The drugs were probably a very important factor in causing respiratory difficulties. I'm not talking about intoxication. I'm talking about complications as a result of the drugs. There was a high content of morphine in her system, it wasn't at the poison level, but morphine is a depressant and in large doses affects the breathing of a person.[61]

Despite the risks of many of the drug therapies and surgical procedures offered to acne sufferers in the post-war period, however, many adolescent acne sufferers, their parents and their physicians clearly felt that the potential for eradicating both pimples and the scars they often left behind was ultimately worth the risk.

Conclusion

In the post-war period, acne was constructed as a threat to both the emotional well-being of teenage Americans and, ultimately, American social order. Physicians, journalists, sociologists and criminologists all warned of the significant impact acne could have on the psyche of the baby-boom generation. Paralleling the development of adolescent medicine and the worries about the mental health of Americans, acne was portrayed as an ailment which had to be overcome at all costs. Furthermore, in a broader sense, the concerns about acne were also linked to wider cultural anxieties about youth mental health, juvenile delinquency, sexual promiscuity and racial unrest. Are such apprehensions still as prevalent in modern-day culture? The simple answer is yes. Anti-acne drug manufacturers have been recently found

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[60] Mackey, "Death Linked to Skin Treatment."

[61] Steve Kowich, "Acne Clinic Had Cosmetic Permit Only," *The Montreal Gazette* (September 13, 1973): 1.

guilty of claiming that teenage consumers who fail to use their product will become victims of bullying. In September 2017, the advertising watchdog banned the makers of Proactiv+ from showing their anti-acne advertisements during children's TV shows commercial slots. The adverts featured Hollyoaks actress Jorgie Porter tearfully describing the bullying she received at school as a result of her acne, and explaining her 'happiness' after discovering Proactiv+. The advertising watchdog, however, concluded that the adverts essentially implied that 'teenagers who have bad skin but don't use Proactiv+ are more likely to be bullied'.[62] In recent years, dermatologists, in particular, have warned of the threat visible skin conditions like acne pose to the mental well-being of adolescent children with many claiming that 'it is important to identify and treat such teenagers early to reduce the future socio-economic burden of their acne'.[63] While acknowledging that being teased as a result of suffering from acne often leads to 'adverse psychological sequelae including stigmatization', some dermatologists have gone further and argued that the condition is linked with increased suicidal ideation in adolescents.[64] Despite being linked with causing depression in adolescent patients, some have claimed that the powerful acne drug, Isotretinoin, (Accutane) actually reduces the severity of mental health problems in this cohort on account of its unrivalled ability to treat even the most stubborn forms of acne.[65] Although the debate over whether or not suffering from acne does lead to an increased chance of developing a serious mental illness continues, groups such as physicians, dermatologists, mental

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[62] Anon, "Anti-Acne Advert Featuring Actress Jorgie Porter Banned from Children's TV," *BBC Newsbeat* (September 27, 2017), http://www.bbc.co.uk/newsbeat/article/41410677/anti-acne-advert-featuring-actress-jorgie-porter-banned-from-childrens-tv.

[63] Nigel Walker and Lewis Jones, "Quality of Life and Acne in Scottish Adolescent Schoolchildren: Use of the Children's Dermatology Life Quality Index© (CDLQI) and the Cardiff Acne Disability Index© (CADI)," *Journal of the European Academy of Dermatology and Venereology* 20, no. 1 (January 2006): 45–50.

[64] Parker Magin, Jon Adams, Gaynor Heading, Dimity Pond, and Wayne Smith, "Experiences of Appearance-Related Teasing and Bullying in Skin Diseases and Their Psychological Sequelae: Results of a Qualitative Study," *Scandinavian Journal of Caring Sciences* 22, no. 3 (September 2008): 430–36, https://doi.org/10.1111/j.1471-6712.2007.00547.

[65] Gary L. Peck, David R. Rubinow, Kathleen M. Squillace, and Gail G. Gantt, "Reduced Anxiety and Depression in Cystic Acne Patients after Successful Treatment with Oral Isotretinoin," *Journal of the American Medical Association* 17, no. 1 (July 1987): 26–31, https://doi.org/10.1016/S0190-9622(87)70166-2.

health professionals, teachers and parents must continue to ensure adolescent patients receive the appropriate treatment. Whether or not such treatment should include dangerous drugs such as Isotretinoin, however, is very much open to debate. Finally, while the presence of acne is believed to have a negative effect on adolescents' 'quality of life, self-esteem and mood', it is ultimately not possible to prevent mental illness by solely eradicating the bothersome skin condition. For example, in recent years, studies have shown that, as well as the problem of acne, sufferers may have ongoing problems within their family and social lives which can also negatively affect their mental well-being.[66] With acne normally affecting sufferers during their adolescent years, the condition is but one of a whole host of changes the body undergoes during puberty. In actual fact, it has been shown that, due to a range of factors, adolescents are at a high risk of suffering from depression.[67] Therefore, while preventing acne may help alleviate some sufferers' accompanying depression, the problem of mental illness remains a much more multifaceted problem.

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[66] Lauren K. Dunn, Jenna L. O'Neill, and Steven R. Feldman, "Acne in Adolescents: Quality of Life, Self-Esteem, Mood and Psychological Disorders," *Dermatology Online Journal* 17 no. 1 (August, 2011): 1, https://escholarship.org/uc/item/4hp8n68p.

[67] Karen D. Rudolph and Martin M. Flynn, "Depression in Adolescents," in *Handbook of Depression*, ed. Ian H. Gotlib and Constance L. Hammen (New York: Guilford Press, 2014), 391–409.

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CHAPTER 4

Preventing Mental Illness, Preventing Delinquency: Juvenile Justice and Child Psychiatry in Post-war America

Erin J. Lux

Introduction

The United States was the first country in the modern world to develop a distinct and comprehensive juvenile justice system that encompassed social services, the courts and separate detention institutions for juveniles. These institutions were premised on the connected ideas that juveniles are less responsible for their actions than adults, and that both preventing juvenile delinquency, and providing treatment to juvenile delinquents, would prevent adult crime. At the turn of the twentieth century, progressive reformers emphasised preventing future crime by intervening in at-risk children's lives, and developed a number of institutions that promoted ideal child-rearing practices; engaging with the nascent field of child psychiatry to treat and prevent emotional and psychological disturbances in young children; providing educational opportunities, and improving environments that children were raised in.

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Growing out of this tradition, the fields of juvenile justice and child psychiatry in the United States have a long and intertwined history, and the goal of preventing juvenile delinquency was built into the foundations of American child psychiatry. The Child Guidance movement, which was funded and expanded by the Commonwealth Fund's Programme for the Prevention of Delinquency in the 1920s, explicitly tied mental health services for young people to the prevention of delinquency.[1] Attempts to prevent juvenile delinquency by preventing and treating childhood emotional disturbances through Child Guidance Clinics in the 1920s and 1930s went hand in hand with social work involvement with the earliest juvenile courts. These new child psychiatrists and juvenile justice workers were interested in primary prevention—preventing disturbances and delinquencies from occurring in the first place—but also secondary and tertiary prevention—preventing disturbances and delinquencies from worsening or reoccurring. Furthermore, the foundational beliefs of juvenile justice—that younger people were more able to be rehabilitated, that their characters had a special kind of malleability, and that they were able to reintegrate into society after a period of treatment, which would prevent future criminality—were inherently making a judgement about the distinct psychology or neurology of children.

By 1940, the American Law Institute, a group founded in 1923 by law professors, lawyers, judges and other legal professionals to promote and clarify American law and draft model legislation, had created model legislation for 'Youth Authorities' which would combine mental health with environmental and legal efforts at preventing both emotional disturbances and juvenile delinquency. This model legislation would be highly influential in expanding the definition of juvenile delinquency and shaping both the federal youth justice system and those of the largest US States, with California being the earliest adopter of the Youth Authority model. However, these highly ambitious pieces of legislation called for widespread involvement of the Youth Authority in all aspects of a young person's life, long custodial sentences, and high levels of engagement by mental health professionals. Legislation drafted by legal professionals, and institutions created and run by corrections professionals, did not take into account the professional ambitions of mental health workers,

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[1] Margo Horn, *Before It's Too Late* (Philadelphia: Temple University Press, 1989).

especially child psychiatrists, nor did they anticipate changing trends in child and adolescent health care provision.

During the 'long 1950s',[2] a period from the late 1940s through early 1960s, defined by methodical policy reform, infrastructure building, the ideal of progress, and consensus politics, it was possible for post-war optimism and cold war concerns about the place of young people to combine with professional ambitions to create a system that rested on preventing and treating mental illness, thereby preventing delinquency. Psychiatric and psychological theories therefore had a profound effect on the development of the juvenile justice system in the post-war years, as criminal justice workers sought to join the ever-growing ranks of respectable professionals, and establish themselves as a healing profession, capable of contributing to a better America through reforming criminals and preventing recidivism. As a medical, healing profession itself, changing approaches to child psychiatry, therefore, had the power to influence correctional policy and practice. The ability of mental health professionals to provide a rationale for investing in juvenile justice not only as a last resort to contain social problems but as a part of a continuum of care and prevention made working with these professionals and adopting their ideas very attractive. Within the context of a culture that was increasingly turning its attention toward its young people and concerned about its future in a post-atomic, cold war world, preventing juvenile delinquency and mental ill-health among young people became an issue of the highest importance. The historiography of the changing role of children and teenagers in mid-twentieth century United States is extensive, reflecting on issues such as newfound economic independence provided by employment in the booming post-war economy, the freedom provided by access to vehicles,[3] the high school as a new nexus of socialisation which threatened adult authority[4] and increased emphasis on educational performance (and pathologising those who did not meet

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[2] David R. Mayhew, "The Long 1950s as a Policy Era," in *The Politics of Major Policy Reform in Postwar America*, eds. Jeffrey A. Jenkins and Sydney M. Milkis (New York: Cambridge University Press, 2014), 27–47.

[3] Judith Sealander, *The Failed Century of the Child* (New York: Cambridge University Press, 2006).

[4] James Gilbert, *A Cycle of Outrage* (New York: Oxford University Press, 1986).

standards) in the face of the threat of Soviet technological advancement.[5] These anxieties further fuelled the need for something to be done to prevent juvenile delinquency and young people falling into a life of crime.

Examining material published in the *American Journal of Psychiatry* and *Prison World*[6] during this period, this chapter shows two fields starting from very similar concerns—behaviour of young people, preventing emotional disturbances from worsening, and ultimately safeguarding the prospects of the largest generation in American history—but ultimately failing to adequately collaborate due to conflicting professional developments, mismatched public standing, and the realities of working with a system based on criminal justice, rather than medical, institutions. By the mid-1960s, preventive and rehabilitative measures such as youth authority involvement in non-criminal behavioural issues and long, indeterminate sentences were being challenged as unconstitutional and by the 1970s, California's youth justice system would be notorious for its size and brutality. Despite being pioneers in creating distinctive institutions for young offenders and in taking a preventive approach to crime, the United States now has a dramatically higher rate of juvenile incarceration than any other developed country, with few protections to prevent juveniles from being charged, tried and sentenced as adults.

A Correctional Beveridge Plan

In 1943, *Prison World*, the journal of the American Prison Association, published a full issue titled 'Penology Looks Toward a "Beveridge Plan"'.[7] Seeing the condition of the correctional system as a result of neglect and lack of funding during the Depression and the War, and looking abroad to the ambitious ideas being developed to reform every aspect of British society, they published a series of articles from criminologists, high government officials and prison wardens calling for the reforms they wanted to see in the justice system. These hopes included

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[5] Matthew Smith, *Hyperactive* (London: Reaktion Books, 2012).

[6] The official journal of the American Prison Association, both renamed to the *American Journal of Correction* and American Correctional Association, respectively, in 1954 to reflect their growing emphasis on both correction/rehabilitation and attempts to project a professional image.

[7] *Prison World* 5, no. 3 (1943).

development of centralised tracking of statistics[8] and planning for crime prevention[9]—explicitly connecting preventing juvenile delinquents from graduating to adult crime with medical epidemiology and disease prevention. They also proposed radically reconsidering the overall approach to juvenile delinquents and youthful offenders due to the War's threat to what at least one writer considered the 'fundamental concept' in American life of delayed adulthood.[10]

By positioning themselves as being the potential beneficiaries of a 'Beveridge Plan', writers for *Prison World* were associating corrections—especially juvenile corrections—with the kinds of ambitious universal social and health services proposed by William Beveridge, arguing that they could be an integral part of defeating societal evils alongside social and health services, as well as a necessary control on social problems. To achieve this, however, they would need qualified personnel, and for corrections workers to be treated as civil servants and hired based on merit,[11] able to provide preventive measures like recreation, housing, guidance, medical care and employment.[12]

Although it must have taken a significant effort of imagination and recruitment to draft such ambitious plans and to involve such figures as Thorstein Sellin, a pioneer in American criminology, and G. Howland Shaw, then the Assistant Secretary of State, harder still would be finding support for implementing these plans. Years of economic depression and war had impeded access to staffing and material for building, while the war effort had also siphoned off psychiatrists, including child psychiatrists. Indeed, in his annual roundup of the developments in child psychiatry for *American Journal of Psychiatry*, Leo Kanner—generally regarded as the father of American child psychiatry, author of the first training manual for child psychiatrists, and first to describe autism—noted that many child psychiatrists had been diverted to the war effort, with 23%

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[8] Thorsten Sellin, "Recommended: A Standard for Penal Statistics," *Prison World* 5, no. 3 (1943): 4–5 (4).

[9] Saul D. Alinsky, "Crime Prevention," *Prison World* 5, no. 3 (1943): 5–6 (5).

[10] G. Howland Shaw, "Juvenile Delinquency," *Prison World* 5, no. 3 (1943): 8–9 (8).

[11] William J. Ellis, "Qualified Personnel—A Correctional Requisite," *Prison World* 5, no. 3 (1943): 11–12 (11).

[12] Joseph W. Sanford, "Penology Must Make Its Post-war Plans Now," *Prison World* 5, no. 3 (1943): 16–17 (16).

of the psychiatrists who were members of the American Orthopsychiatric Association enrolled in the military.[13]

Psychiatrists' concern about the War's impact extended not only to the depletion of their ranks in civilian practice, but also to the effects that it would have on future childhood maladjustments and delinquency. In the same article where he noted the effect of military needs on the availability of child psychiatrists to the civilian population, Kanner highlighted a study that suggested that the War was contributing to delinquency not only through social changes, giving children more freedom and responsibilities, but especially through disruption of their families—the study found that half of delinquent children's first offences occurred shortly after a father or brother had enlisted.[14] Douglas A. Thom wrote for *American Journal of Psychiatry* that the social position of children occasioned by the needs of the wartime economy was a major cause of delinquency. His definition of 'child' included 16-year-olds who were working full time and earning a wage—although this definition of childhood was a controversial one. He worried that the gap between children's newfound ability to earn a wage and their maturity was leading to role confusion between parents and children. These circumstances, he argued, had made all children, and not just those who were 'inadequate' and 'inferior intellectually', vulnerable to delinquency. Furthermore, he was concerned that the shifting populations of military camps near civilian residential areas and other disruptions to the 'normal way of life' created a society based on temporariness and short-term thinking that degraded standards of behaviour and encouraged indulgence in momentary pleasures.[15]

Much like those in the field of corrections, however, Thom suggested an ambitious response to straitened circumstances. He argued that because of the reduced availability of specialists, it was necessary for professionals to consider what they could do for children *as a group*

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[13] Leo Kanner, "Child Psychiatry. Mental Deficiency," *American Journal of Psychiatry* 101, no. 4 (1945): 528–30 (528).

[14] Ibid., 529.

[15] Douglas A. Thom, "Sociological Changes Predisposing Toward Juvenile Delinquency," *American Journal of Psychiatry* 100, no. 4 (1944): 452–55 (452). An important figure worth mentioning in his own right, Thom was a pioneer of infant mental health in Boston in the 1920s who became a Lt. Col. in the US military. The clinic he founded is still practicing today.

rather than for individual children.[16] One solution he advocated was the expansion of childcare provision for working women, and training the staff of these day care centres in child guidance in order to reach the largest possible number of children and thereby prevent both mental health problems and delinquency. In this way he proposed an even closer relationship between psychiatry and community services and expanding training in psychiatric concepts to non-medical workers engaging with children. While acknowledging that during normal circumstances, delinquency may be caused by children who had disorders, he believed that the lack of available psychiatric expertise and the unusual circumstances of a wartime economy necessitated a broad, community-based approach.

The role of non-psychiatrists in spreading psychiatric ideas for preventing delinquency to the community would prove to be an important one for popularising interventions with pre-delinquency children. In 1949, the *American Journal of Psychiatry* published a report of a trial wherein the parents of children suspected by their elementary school teachers and principals of being pre-delinquent were provided with group therapy conducted by psychiatric social workers.[17] This programme demonstrates that there was an expansion of training in psychiatric ideas to teachers, an attempt to single out potentially troublesome but otherwise normal, non-delinquent children, and to intervene through offering group therapy to the parents in order to prevent delinquency. Even with the depletion of the psychiatric resources available to civilians, however, the War also provided an opportunity for psychiatrists to prove their usefulness to both the general public and to corrections. In an article for *Prison World*, William C. Menninger, director of psychiatry to the military, wrote that the war had given psychiatrists 'carte blanche' to prove its value to the correctional field in rehabilitating criminals and preventing future recidivism.[18]

Despite these challenges, and with the enthusiasm of high-ranking psychiatrists like Menninger, lawmakers and correctional professionals throughout the war years drafted plans for how they would reshape

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[16] Ibid., 453.

[17] A. D. Buchmueller and Margaret Gildea, "A Group Therapy Project with Parents of Behaviour Problem Children in Public Schools," *American Journal of Psychiatry* 106, no. 1 (1949): 46–52 (46).

[18] William C. Menninger, "Psychiatry in Military Correctional Institutions," *Prison World* 7, no. 4 (1945): 4, 27–29 (4).

justice away from the 'inhuman country jail and chain gang situations' of the past and toward a future based on collaboration between corrections, psychiatry, and social services that would prevent crime before it started, and rehabilitate those who had offended as a form of secondary or tertiary prevention of recidivism.

One of the new institutional experiments that began during the War but spread quickly afterward was the Youth Authority model, integrating police, education, social services, medical services, psychiatry and corrections. This model reflected the American Law Institute's model Youth Correction Authority Act, drafted in 1940, which advocated integration of services for young people at risk of delinquency and required treatment to be the primary goal of juvenile justice.[19] The model Act caused significant debate between the psychiatric, legal and correctional community. While the American Psychiatric Association created a committee to study and report back on the model Act, the legal community was divided as to whether it was a necessary legislative development or an unjustifiable assault on individual rights.[20] Regardless, a bill based on the model Act was passed in California, the first state to do so (six others attempted and eventually rejected their bills), in 1941 and then amended in 1943. The version as implemented in California expanded youth justice to those under the age of 23, allowing indeterminate sentences curbed only by age limits on involvement in the youth justice system. It also empowered the Youth Authority to engage in preventive measures through school mental hygiene services and community organisations, and to assist in developing Community Councils to deal with both delinquency and youth crime.[21] A benefit that the author particularly singled out was the ability of the Act to 'make possible long periods of detention for the psychopathic delinquent … from whom society has a right to be protected'.[22] The integrated nature of these services and the push for

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[19] Harvie Coghill, "The Proposed Youth Correction Authority Act," *American Journal of Psychiatry* 99, no. 6 (1943): 890–93 (890).

[20] Jerome Hall, "Youth Correction Authority Act—Progress or Menace?" *American Bar Association Journal* 28, no. 5 (1942): 317–21 (317) and William Draper Lewis, "The Youth Correction Authority Act, A Model," *American Bar Association Journal* 28, no. 5 (1942): 322–24 (322).

[21] O. H. Close, "The California Youth Authority," *Prison World* 5, no. 5 (1943): 15, 27–28 (15).

[22] Ibid., 28.

increasingly lengthy sentences dependent upon assessment of the child's risk or needs, rather than based on the nature of the offence, would have significant consequences for all involved—whether constitutional challenges on the basis of denial of rights to due process or challenges to psychiatric authority when treatment and prevention programmes proved less than effective. This would be the case especially as long sentences for the purpose of rehabilitation and prevention became normalised for even minor offences, and children who would not be considered psychopathic or seriously disturbed.

After the war, juvenile justice legislation—influenced by the model law that created the California Youth Authority—continued to develop rapidly. New York State passed eight laws on delinquency in 1945, establishing the State Youth Commission.[23] These pieces of legislation enabled the State of New York to provide assistance to smaller communities for preventing delinquency (primarily by helping them to pay for professional services, including psychiatrists), established a five-year maximum sentence for young offenders sent to Reformatory,[24] provided more flexibility to transfer inmates between the Departments for social welfare, mental hygiene, and correction and authorised 'boarding-out' care for children on parole. One of the institutions that these new laws funded was the creation of a 'Reception Centre' for male offenders between the ages of 16 and 21 to ensure each offender was 'carefully studied' and the correct form of individualised treatment prescribed—a process which would take approximately 60 days.[25] This was deemed to be just in time as the FBI reported that arrests of males under the age of 21 had increased 10.1% in 1945 and that the group with the largest number of arrests were 17-year-old males. While the FBI numbers have been contested,[26] they were the ones repeatedly cited throughout

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[23] Charles Breitel, "Governor Dewey's Program for the Prevention of Delinquency," *Prison World* 8, no. 1 (1946): 4–5, 32 (4).

[24] This may seem to cut against the larger point that juvenile justice administrations inflated sentence length, but 5 years would be a long sentence when the average sentence length of people released in 1955 (and thus incarcerated around this time) was 23 months. Bureau of Justice Statistics, *Historical Corrections Statistics, United States, 1850–1984*, 164.

[25] Glenn M. Kendall, "Elmira Reception Centre," *Prison World* 8, no. 2 (1946): 8–9, 27–29 (9).

[26] See Sealander, *The Failed Century of the Child*, for discussion of statistical manipulation and different definitions of delinquency between the FBI and Children's Bureau for more.

the issues of *Prison World*.[27] New York State also had a separate institution for 'defective delinquents'—those who had committed a crime but were deemed to have a mental deficiency. In 1948 there were 49 juveniles in this facility (in addition to adults, housed separately), who were, in theory, prescribed 'individual treatment' by a team consisting of the superintendent, assistant superintendent, a physician, psychiatrist, psychologist, and educator, among others. Those who were thought capable were given military training, and some even joined the National Guard, despite their diagnosis of feeblemindedness.[28]

The Youth Authority model continued to be implemented, debated, and modified throughout the 1940s and into the 1950s despite its first application being in 1941. Roy McLaughlin, superintendent of a Connecticut training school, contributed a column to the *American Journal of Correction* (*AJC*) concerned that the Youth Authority model was bad for children. In his view, it conflated children with youth (in his definition, under 16 and over 16) and even in its name using the term 'authority' in the name of the administration was inappropriate for delinquent children, who he termed 'socially handicapped children'.[29] He argued that the entire Youth Authority concept fell into old thinking that centred on courts, justice institutions, and criminal responsibility, and argued in favour of a social work model—especially as Connecticut, where courts had the option to decide if a child was delinquent or neglected, judged nearly three times as many children to be neglected as they did delinquent. The debate continued in 1950, when John Ellingson, a special advisor to the American Law Institute, the group that drafted the original model Youth Corrections Authority Act, gave a session on it at the annual Congress of Correction. By this time, the Youth Authority model as written by the American Law Institute had been implemented, to one degree or another, in five states (California, Minnesota, Wisconsin, Massachusetts and Texas) with New York having implemented some similar measures. Ellingston attempted to define the Youth Authority model as one which provided 'treatment to each

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[27] Kendall, "Elmira Reception Centre," and "Flash! Crime," *Prison World* 8, no. 2 (1946): 8–9, 27–29 (11).

[28] Thomas J. Hanlon, "The Defective Delinquent and the Institutional Program," *Prison World* 10, no. 1 (1948): 12–13, 29–31 (12).

[29] Roy L. McLaughlin, "Is Youth Authority a Design for Children?" *Prison World* 10, no. 5 (1948): 8–9 (8).

offender based on an understanding of the causes of his actions and of his emotional needs in the light of modern insight into human nature'.[30] Perhaps unsurprisingly given his position, the writer was completely committed to the Youth Authority concept and did not address the criticisms it had faced, but blamed some of its failures on a punitive public, reactionary editorial writers, and stingy state legislatures, while stating that it was only starting slowly, much like the juvenile court concept, and would soon be in every state in the nation.

Some of these principles would make their way into the Federal Youth Corrections Act that passed at the end of 1950. It contained several of the same measures: emphasis on individualised treatment, long indeterminate sentences (though capped at six years for less serious offences, or at the maximum length of the adult sentence for more serious offences) and applied to all offenders under the age of 22. While not conforming entirely to the Youth Authority model, Director of the Federal Bureau of Prisons James V. Bennett cited the model Youth Corrections Authority Act as inspiration for the federal Act. He explicitly stated that the aim was to prevent future and more serious offending by identifying the causes of the youth's delinquency and treating them. The Act, like many Youth Authority programmes, also provided for the creation of an advisory council to examine causes of crime and possible preventive measures.[31]

All of these ambitious plans for preventing delinquency and future adult crime sounded optimistic and benevolent, but they also had a darker side. A focus on prevention and integrating services pushed criminal justice into the lives of children who had committed no crimes, and required very long sentences to rehabilitate or correct the delinquent. The meaning of 'prevention' itself could also carry eugenic connotations. One psychiatrist, writing for *Prison World*, was so optimistic that America would implement its own Beveridge Plan that psychiatrists seeking to prevent crime and treat criminals would no longer need to worry

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[30] John R. Ellingston, "Is the Youth Authority Idea Really Paying Off?" *Prison World* 12, no. 6 (1950): 10–11 (10). One reason the New York model didn't conform to the "Youth Authority" model defined here was the limit of 5 years on sentences. Ellingston is clear that the first condition of the Youth Authority model of treatment was indeterminate sentencing.

[31] James V. Bennett, "The Federal Youth Corrections Program," *Prison World* 13, no. 1 (1951): 13, 27–28 (13).

about ‘accidental’ criminals, pushed into maladjustment and crime by environmental causes, and would only have to deal with ‘feebleminded’ and ‘psychotic’ criminals, specifically preventing sociopathic personalities forming in early childhood—and, therefore, psychiatrists should focus their attention on aiding child guidance clinics.[32] This same writer, however, also advocated for denying marriage to people deemed ‘feebleminded’ and obliquely suggested sterilisation (‘How are you going to prevent illegitimate births among those who are denied the right to marry? … I know how it *could* be done’) for anyone under the mental age of 12 to prevent the spread of their ‘defective germ plasm’. The same progressive instincts that pushed the editors to collect visions for a model of corrections that aimed to prevent rather than incarcerate, and heal rather than punish, also spurred them to publish pieces where *prevention* was synonymous with denying reproductive rights to people deemed ‘inferior’.

Policy Meets Practice

However optimistic the lawmakers, academics, psychiatrists and correctional professionals who were drafting model legislation and planning future institutions were, however, the reality of the juvenile justice system in the United States at mid-century was that it was disunited, had suffered many years of neglect, and was built on very old, unsuitable infrastructure. In 1950, the journalist Albert Deutsch, author of *The Shame of the States*, published *Our Rejected Children*,[33] an investigation into the condition of juvenile institutions in the United States. Deutsch stated that he chose only to investigate the most developed states—in order to show how poor conditions were across the country without being accused of muckraking—and many of the states that he covered had implemented the Youth Authority model. Among isolated pockets of good practice, he found institutions where children were racially segregated (with the result of escalating tensions and discipline problems), run down facilities, children with emotional disorders not receiving treatment, and completely unsuitable and unqualified staff. He reserved particular ire for California, home of the oldest Youth Authority, where he

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[32] J. G. Wilson, “Psychiatric Aspects of Crime as It Affects Social Security After the War,” *Prison World* 5, no. 3 (1943): 23–24 (23).

[33] Albert Deutsch, *Our Rejected Children* (Boston: Little Brown, 1950).

found an epidemic of gas-sniffing among children who were neglected, bored and had little educational opportunity. He interviewed staff at Sacramento and Ventura, and found that not one of them was proud of their job or institution. Many complained about a lack of access to personnel and materials due to the war, despite the progressive legislation.

One way the American Correctional Association hoped to improve the running of institutions and combat this gap between theory and practice was by including, starting in 1947, a 'Correction Officer's Training Section' in each issue of *Prison World*, focusing on one new concept or skill in each issue, through which they hoped to improve correction officers' understanding.[34] This was an important step, as an issue that Deutsch had singled out during his investigation was the almost total lack of standards for who could become a correctional officer, even one dealing with children. Indeed, one New York State official had told him that they were 'glad to take anybody with two legs', and Deutsch had found men with no qualifications acting as supervisors.[35] Despite this mismatch between ambition and the capabilities of the staff, this feature continued and a 1950 column—co-written by Walter M. Wallack, an eminent penologist and warden, and the chief medical officer of the US Public Health Service—focused on 'What has psychiatry to offer in correctional work?'[36] The warden wrote that psychiatry was an expanding science which, in the future, would be one of the most important tools available to penologists and correctional officers, and that it dealt with the core corrections—changing human behaviour. He acknowledged that some of the resistance to psychiatry by correctional workers was due to the difficult language that psychiatrists used, which made their concepts difficult to understand. In his section, the medical officer wrote that the lack of influence of psychiatry, as yet, in the correctional system was in part due to the insufficient supply of psychiatrists and advocated that correctional workers should learn 'a few basic principles involved in the production of the psychoneuroses' in order to help inmates since, in his view, psychoneuroses produced a considerable amount of delinquent behaviour. The rest of the article went into

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[34] Edward M. Wallack and Frederick C. Bennett, "Correctional Officers' Training Section," *Prison World* 9, no. 4 (1947): 16–17, 26, 30 (16).

[35] Deutsch, *Our Rejected Children*, 85.

[36] Walter M. Wallack and Heinz R. Weisheit, "Correctional Officer's Training Section," *Prison World* 12, no. 1 (1950): 16–17, 24–29 (24).

considerable detail explaining the history of the theories about anxiety, hostility, psychopathic personality, and paranoia, and the ways these could manifest, how to handle inmates who express these traits and what the usual treatments were. This type of training article suggests how important psychiatry was becoming to justifying a progressive model of corrections that centred on treatment and tertiary prevention. It also, however, demonstrates why some psychiatrists were growing concerned about the provision of training to non-professionals so that they could become, to some degree, 'lay therapists'—much like earlier projects aiming at having teachers trained in guidance.

Whether or not to become further involved in the juvenile justice system was a fraught question for child psychiatrists who were newly establishing their position as a medical specialty. In much the same way that adolescent medicine found itself on the outside of American medicine's focus on organ-and-technology-based specialties,[37] child psychiatry was struggling to be recognised as a legitimate specialty distinct from both psychiatry and paediatrics. Coming out of the War years, new factions developed advocating for different approaches to psychiatry, including group therapy, more outpatient treatment and more interdisciplinary involvement. The Group for Advancement of Psychiatry was one of these. Founded in 1947 by William Menninger and other like-minded psychiatrists who wanted to put their experience in the War to use in public life, they sought to advance research and practice from a social and psychodynamic perspective. Composed of many committees, their Committee on Child Psychiatry advocated for the continuation of interdisciplinary methods used in Child Guidance clinics, and for supporting the role of psychiatric social workers even in therapeutic settings.[38] However, this very interdisciplinary community setting was deeply troublesome to other child psychiatrists.

Dr. David M. Levy, a child psychiatrist famous for coining the term 'sibling rivalry' and originating active play therapy,[39] wrote in the *AJP* in 1952 that 'the early tie-up of delinquency and psychiatry' occasioned

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[37] Heather Munro Prescott, *A Doctor of Their Own: The History of Adolescent Medicine* (Cambridge: Harvard University Press, 1998).

[38] *Basic Concepts in Child Psychiatry* (Report No. 12), Committee on Child Psychiatry of the Group for the Advancement of Psychiatry (New York: Group for Advancement of Psychiatry, 1950).

[39] "Dr. David M. Levy, 84, A Psychiatrist, Dies," *New York Times* (4 March 1977): 33.

by the earliest juvenile psychiatric institutions being founded to address juvenile delinquency had ‘diluted’ the practice of child psychiatry in the United States—which in his view would not have been the case if child psychiatry’s main focus had been neurosis or psychosis in childhood. With the involvement of child psychiatry with philanthropy, social work and juvenile justice in the US alternatively traced back to Jane Addams’ Juvenile Protection Association or William Healy and the Commonwealth Fund’s initial child guidance clinics, there had been nearly 50 years of development of relationships between justice workers, social workers, psychologists and child psychiatrists. Levy argued that this ‘prolonged sojourn … outside the field of medicine’ had been a cause of that dilution, as had attempts by social workers and psychologists to emulate the psychiatrist’s role to gain its ‘prestige’. He was also concerned that, in addition to de-skilling psychiatrists by placing them outside of medical settings, putting too much responsibility in the hands of psychologists and psychiatric social workers, who were not medically trained, would not only allow cases of medical problems like epilepsy and endocrine disorders go undiagnosed and untreated, but would ignore the burgeoning area of pharmacology in child psychiatry.[40]

Levy’s article was published with discussion from both Leo Kanner and Frederick H. Allen, who was a child guidance pioneer in Pennsylvania. Kanner noted that GAP’s statement seemed to use ‘child guidance’ and ‘child psychiatry’ synonymously, erasing child psychiatrists who worked outside of child guidance clinics. Allen, as a veteran of child guidance clinics, was more sympathetic to the division of labour between social workers, psychologists and psychiatrists. Where Levy wrote of the need for psychiatrists to be firmly in charge of the clinic and to merely incorporate data from what he saw as supporting professions, Allen saw different professions coming together as child guidance’s greatest achievement, and felt that to avoid ‘prestige strivings’ or one group being called upon to control the other, it was important to differentiate the roles of the three professions without subordinating one to the other.[41] With these ongoing debates about how child psychiatry should work alongside allied professions, trying to negotiate its position alongside another, lower status field could be a difficult task.

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[40] David M. Levy, “Critical Evaluation of the Present State of Child Psychiatry,” *American Journal of Psychiatry* 108, no. 7 (1952): 481–94 (481, 485 and 489).

[41] Ibid., 492.

These other professions that child psychiatrists worked alongside, such as social workers and psychiatric social workers, and correctional officers and wardens, could be classed among those that Chris Nottingham described as ‘insecure professionals’. He defined insecure professionals as members of emerging ‘socialised professions’ whose work is imposed upon their clients, who deal with a broader client base that encompasses the lower classes, and whose role is enforced, rather than simply regulated, by the state.[42] Much like the asylum attendants or mental hospital nurses of mid-twentieth century Britain whom Vicky Long also identified as insecure professionals,[43] correctional workers also had to contend with a reputation of being workers recruited for their ability to control dangerous inmates, rather than for any special professional qualities. Long also noted that psychiatry, while certainly a part of the traditional, established profession of medicine, lacked the professional status of other branches of medicine.[44] This was doubly the case of child psychiatrists, who, due to the legacy of child guidance, worked closely with insecure professionals and the broad, involuntary client base of delinquent children.

While child psychiatrists struggled for recognition of their specialty, medicine was, in the post-war years, emerging as the high watermark of post-war professionalism and progress. The improvements to medical care that emerged during and after the war—the availability of penicillin in the 1940s, the first successful kidney transplant in 1952, polio vaccination in 1954—demonstrated the value of medical doctors to everyday Americans and was a rapid shift from the often ineffectual (and even lethal) practices of the pre-antibiotic era. While the professionalisation and consolidation of evidence-based practice was not uncontested—the American Association of Physicians and Surgeons was founded in 1943 not only to protest state involvement in healthcare funding, but also to oppose any mandate that physicians must practice evidence-based medicine—it did create a near-unified front demonstrating the power of professionalisation, science, and progress. Doctors quickly moved from a profession that could rarely be relied upon to trusted figures who would save millions of lives.

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[42] Chris Nottingham, “The Rise of the Insecure Professionals,” *International Review of Social History* 52, no. 3 (2007): 445–75 (446–59).

[43] Vicky Long, *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870–1970* (Manchester: Manchester University Press, 2014), 81.

[44] Ibid., 65.

Psychiatrists, on the other hand, initially lacked access to the kinds of silver bullets that biomedicine possessed thanks to the fortuitous discovery of penicillin. Despite being board-certified medical doctors, adult psychiatrists in the United States had, for much of the country's history, been associated with the running of asylums. This was not a position of professional prestige, as these hospitals, for the most part, were located in rural settings and housed a large number of people who were long-term residents due to illnesses that were degenerative and chronic in nature, including many elderly people. However, over the course of the twentieth century, new trends began to emerge—whether psychosurgery, which tied psychiatry to neurology and thus brought it closer to physical medicine, or psychoanalysis, which emphasised the personal relationship between doctor and patient and was usually carried out in urban, private practices, far from the image of the asylum.

However, one of the biggest changes to affect psychiatry was the introduction of chlorpromazine (better known as Thorazine) in 1954. Thorazine, a first-generation antipsychotic, was hailed as a miracle drug and psychiatry's silver bullet, famed for its ability to take people out of the back wards and either return them to the community or at the very least provide a more peaceful, manageable life. Thorazine was soon followed by other drugs, which quickly made their mark on both the institution of the asylum and on the public. These drugs could not be the silver bullet for mental illness that penicillin was for biomedicine, however—none of these medications cured, only treated symptoms, and had to be taken regularly despite often serious side effects.

Despite these changes and an increased focus on surgical and pharmaceutical treatments, a book written by a physician accusing psychiatry of 'not being a branch of medicine at all', concerned only with making money, and totally captivated with psychoanalysis to the exclusion of biomedicine, turned enough heads that it was reviewed in *AJP* in 1959.[45] The book was written after the author French physician and surgeon Jacques M. May's experience of an analyst dismissing his sons' developmental disorders as being caused by 'parental rejection' and recommending a long course of analysis for the parents without any medical testing for the sons. In May's view, psychiatry—especially regarding children—had 'moved backward' by shifting away from biomedicine and instead

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[45] Henry A. Davidson, "Review: A Physician Looks at Psychiatry," *American Journal of Psychiatry* 115, no. 10 (1959): 952–53 (952).

embracing psychotherapy. The reviewer, while refuting many of the author's points, conceded that he was 'not 100% wrong' and that it came 'close enough to the truth'; he believed his fellow psychiatrists needed to read the book and reflect on its contents. That the *American Journal of Psychiatry* considered this book important enough to review potentially reveals an insecurity about the direction psychiatry was moving in and its place as a medical field.

All of these professional struggles took place within a larger political and cultural context. Regardless of the differences between mental health and correctional professionals, one thing that they had in common was that they were more subject to control and interference by legislation and changing political cultures than many other professions. Psychiatrists, unlike most doctors, sometimes treated patients who have been committed to their care by the state—a marker of the insecure professional—and correctional professionals, too, were in the business of rehabilitating people who were under their care due to statutory decree. Political interference with the justice system did not only occur in changeover of staffing after elections or the way funding could be bolstered and slashed in line with electoral campaigns. The 1954 Congress of Correction featured a report from Richard Clendenen, Executive Director of the U.S. Senate Subcommittee to Investigate Juvenile Delinquency (and one of the witnesses to testify, and former Chief of the Juvenile Delinquency branch of the Children's Bureau). Despite his position in charge of this inquiry he seemed hesitant about the Senate's capacity or suitability to oversee an investigation into such a large and complex matter. He stated that nearly everyone in the United States had an opinion on the causes and cures of delinquency, but that it was up to 'the more sophisticated' and the 'enlightened' to promote a treatment-based approach to the prevention and cure of delinquency and to counteract the positions put forth by 'the punitively minded' and act 'against apathy and indifference' and 'blind and short-sighted economy'. Despite his confidence in the correctness of the treatment approach, he acknowledged that too much was still unknown and that people who tried to attract funding to pet projects—like playgrounds and community centres—by advertising them as counter-delinquency programmes were playing a dangerous game when the community would, inevitably, be disappointed by not seeing a corresponding drop in crime rates.[46]

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[46] Richard Clendenen, "The U.S. Senate Looks at Juvenile Delinquency," *American Journal of Correction* 16, no. 6 (1954): 11–12.

By 1958 the report of the Sub-Committee had been reported and *AJC* had published its response. Their writer, the Director of the District of Columbia Department of Correction, found much to praise in the report for the thoroughness of the investigation and the clarity of the writing.[47] He reported that one of the developments that came from the investigation was Senate Bill 431—the Delinquent Children's Act. While this would not become law for another three years, it would provide $22.5 million in aid to state, city and county jurisdictions to prevent delinquency, as well as support for training staff and conducting research.

Challenges to the Prevention Model

Despite increased funding for research, doubts were raised about the validity of the 'prevention' and rehabilitation approach to juvenile justice. There was debate about whether psychiatrists should be involved with the justice system at all or whether this was an inappropriate use of their expertise and a detriment to their professional standing. One study published in 1954 questioned the value of prevention and early intervention on the basis that the human personality is more plastic in childhood,[48] while another highlighted by Kanner's annual roundup of child psychiatry developments in 1958 suggested that high-risk delinquent youth received little to no benefit from clinic-based psychiatric interventions.[49] A 1951 article by Starke Hathaway and Elio Monchesi, two psychologists who were promoting the Minnesota Multiphasic Personality Inventory for early detection of delinquency, also noted the lack of evidence for early intervention as a defence against crime.[50] Another article, by researchers Clarence Sherwood and William Walker, about a programme—Highfields—in which approximately

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[47] Donald Clemmer, "A Brief Review of the Report on Juvenile Delinquency by a Committee of the United States Senate," *American Journal of Correction* 20, no. 1 (1958): 3–5, 23 (3).

[48] Ian Stevenson, "Is the Human Personality More Plastic in Infancy and Childhood?" *American Journal of Psychiatry* 114, no. 2 (1957): 152–61 (152).

[49] Leo Kanner, "Child Psychiatry. Mental Deficiency," *American Journal of Psychiatry* 114, no. 7 (1958): 608–11 (609).

[50] Starke R. Hathaway and Elio Monachesi, "The Prediction of Juvenile Delinquency Using the Minnesota Multiphasic Personality Inventory," *American Journal of Psychiatry* 108, no. 6 (1951): 469–73 (469).

20 boys would be sent to a non-custodial institution meant to have a non-institutional feel for four months at a time and participate in a type of group therapy called guided group interaction—was a cause for concern for writers for the *AJC*. Sherwood and Walker went through an academic report that had been published in support of the Highfields method and found significant inconsistencies in the methodology and no real evidence for its ability to be expanded to other institutions, groups, or age ranges, or to be significantly scaled up.[51] The director of the institution responded to the article in the next issue and addressed some of the methodological concerns, but concurred that 'too often, new techniques are introduced and find their way into our correctional institutions without adequately exposing them to the scrutiny of scientific research'.[52] This concern with inadequate research did not extend only to this project, but to the larger correctional reform and treatment system. An article in *AJC* in 1962 referred to the state of correctional research as a 'crazy-quilt' and worried that, if all the studies were properly collated and examined, correctional professionals would be 'tremendously embarrassed' how little had been gained from 'sporadic ad hoc studies'.[53]

In 1961 President Kennedy signed the Juvenile Delinquency and Youth Offenses Control Act of 1961. This legislation was hailed by Peter Lejins, president of the American Correctional Association, in his column on the state of corrections in 1962. He noted that recognition that many adult criminals had once been juvenile delinquents was not new, and pointed out cases in the nineteenth and early twentieth century. He felt that this time, however, with new federal budgetary appropriations for *preventive* programmes, rather than post-delinquency intervention, that things could change.[54] He reiterated this position the next year, arguing that the correctional approach, as distinct from the punitive approach, rested on the belief that all human behaviour was due to

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[51] Clarence C. Sherwood and William S. Walker, "Some Unanswered Questions About Highfields," *American Journal of Correction* 21, no. 3 (1959): 8–9, 25–27 (8).

[52] Albert Elias, "Reply to Some Unanswered Questions About Highfields," *American Journal of Correction* 21, no. 4 (1959): 28–31, 34–35 (28).

[53] Alfred C. Schnur, "Correctional Research: A Review and Critique," *American Journal of Correction* 24, no. 1 (1962): 24–26, 28–29 (28).

[54] Peter P. Lejins, "From the President," *American Journal of Correction* 24, no. 6 (1962): 31, 36 (31).

specific causes, with understandable motivations that can be removed or altered, and that the American Correctional Association had succeeded in making this the prevailing orientation of penal systems in America. Nevertheless, he feared that a ‘continued lack of clarity’ about the ‘development of effective correctional programmes’ had impeded progress. He also wondered, in the rush towards treatment, if the penal system had not made a mistake in missing the point that punishment, correction and incapacitation could all be legitimate goals that served each other. He was also concerned with the lack of communication between professionals and educational establishments: the field of criminology was not widely established in American universities, and the professionals who worked in corrections were so diverse in their qualifications that there existed no unified pipeline through which experience and individual research could be fed back into universities.[55]

The preventive and rehabilitative model of juvenile justice was not only challenged on the basis of a lack of research and evidence support, but also on the kinds of sentencing these programmes produced. The need for longer, rehabilitative and preventative incarceration contributed to a prison and juvenile institution building boom through the late 1950s and 1960s, part of a trend that would continue throughout the latter half of the twentieth century. An example given for Wisconsin, neither a particularly large nor wealthy state, with a relatively low crime rate, showed that between 1959 and 1961 they opened two new juvenile training schools with a total capacity of 600 boys, a new forestry camp for juvenile delinquents, and an expansion to the girls’ training school, in addition to a new medium security adult prison and expansions to the state prison and state reformatory, with three new institutions planned to open the following year.[56] This expanded capacity for incarceration of more people for longer terms was billed as a positive, progressive, and treatment-oriented approach of which the state of Wisconsin was to be proud, much in the same way as expanded hospital capacity. New York State, too, celebrated the opening of several new institutions for young offenders in the form of forestry work camps. In 1962 they celebrated

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[55] Peter P. Lejins, “From the President,” *American Journal of Correction* 25, no. 5 (1963): 6–12 (6, 8 and 12).

[56] Sanger B. Powers, “From the President,” *American Journal of Correction* 23, no. 1 (1961): 35.

the opening of the third such facility in 11 months, with a fourth due to be opened in May of that year, and 3 more planned.[57]

This trend towards long, treatment-oriented sentences for minor delinquents in the name of crime prevention culminated in the detention of 15-year-old Gerald Gault of Arizona. Gault was taken into custody on 8 June 1964, charged with having made an obscene phone call to a neighbour. Despite a lack of evidence and Gault pleading his innocence throughout the proceedings, he was adjudicated delinquent and ordered to the state industrial school until he attained his majority—in the case of Arizona, the age of 21. This was a six-year period. Gault, as a minor, had no right to due process and no right to confront his accuser. Gault's parents appealed to the State supreme court, which was then appealed to the Federal supreme court. By the time this case reached the Supreme Court, it was 1967 and dramatic changes to ideas about individual rights—including for people needing treatment—and the rights of defendants had taken place. In an 8-1 decision, they ruled that Gault had a right to due process, including against self-incrimination, to confront his accuser, and to have representation by an attorney, therefore setting the precedent for all juveniles. The sole dissenter, Justice Potter Stewart, defended the lack of due process rights in juvenile court, since the purpose was *correction*, not punishment, and due process rights should only apply to a punishment.

Conclusion

Although, even as late as the *Gault* decision, some justice workers like lawyers and judges still believed that juvenile justice institutions provided treatment and care rather than being places of punishment, this was not the case. Albert Deutsch's 1950 expose on the treatment of juveniles in institutions, *Our Rejected Children*, involved visits to a number of different types of correctional setting for young people, ranging from Detention Centres to Prisons. What he found was a catalogue of violence, often dressed up in language related to psychiatry, treatment and prevention. He saw children subject, essentially, to being punished by high-pressure water hoses under the guise of 'hydrotherapy', but also other types of abuse like lack of access to food, brutality from guards

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[57] Milton Luger, "The Edward R Cass Youth Rehabilitation Camp," *American Journal of Correction* 24, no. 2 (1962): 30–31 (30).

(although officially not allowed), and lack of educational opportunities for the children. This was a particularly grim discovery, as the children themselves could, in theory, be committed to these institutions for truancy.

Justice and penal workers aspired to be part of a growing set of professionals who would rebuild the nation and the world after the Second World War to be better, progressive and just. They wanted to align themselves with other professions who were organising and making a positive difference. Medicine was the model of a profession that science and professional organisation had transformed into a force for good. Criminal justice, seen in its best light, is a discipline that also tries to heal the sick: if a society truly believes in second chances and rehabilitation, then its justice system must repair the damaged citizen and return them to civic health. Children, due to their youth and supposed innocence, have often been seen as ideal candidates for this process. However, political reluctance to use limited government funds in support of those seen as proto-criminals, as well as the inheritance of institutions built based on a very different set of goals, hobbled attempts to create a truly rehabilitative set of institutions. The failure to re-cast corrections as healing profession that could truly prevent additional delinquency would have fallouts over the next decades—as secondary prevention failed, and reoffending continued, it would become easy to believe that when it came to corrections, nothing worked.

CHAPTER 5

Social and Mental Hygiene: Models of Mental Illness Prevention in Twentieth-Century Greece (1900–1980)

Despo Kritsotaki

INTRODUCTION

In 1983 American psychologists John Spaulding and Philip Balch argued that primary prevention was not just a 'much talked about and debated topic in contemporary psychology', that had become a respectable field for USA professionals in the 1970s, but also had 'a considerable history' since the late nineteenth century, manifesting itself as a recurrent interest in and resistance to prevention.[1] Spaulding and Balch referred to different historical models of prevention, some of which were influential beyond the USA, such as mental hygiene, child guidance, eugenics and community mental health. In Greece, prevention was discussed and implemented in the first part of the twentieth century within social

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[1] John Spaulding and Philip Balch, "A Brief History of Primary Prevention in the Twentieth Century: 1908 to 1980," *American Journal of Community Psychology* 11, no. 1 (1983): 59–80 (59).

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hygiene, which was strongly influenced by eugenics, and in the post-war period within mental hygiene, which incorporated basic tenets of social psychiatry.

Starting with early twentieth century and interwar social hygiene and moving to Second World War developments and the emergence of a distinct mental hygiene movement in the 1950s, this chapter demonstrates how ideas and practices of mental illness prevention in twentieth-century Greece were shaped by social circumstances and professional developments within the field of mental health. It shows that models of prevention continuously focused on public education and the protection of childhood, but in the post-war period the emphasis shifted from physical to psychosocial aspects of health promotion. Finally, the chapter argues that, while concepts of prevention became systematised in the second half of the century, their practical impact remained limited throughout the period under consideration. The analysis stops at the end of the 1970s, when the field of mental health was becoming visibly reshaped with new legislation and services, and when biological approaches to prevention, this time through genetics, were returning.

Prevention Before the Second World War: Social Hygiene

In early twentieth-century and interwar Greece mental illness prevention was a rather marginal concern within broader debates on social hygiene. Encompassing the methods and principles for protecting and promoting public health, social hygiene gained momentum as worries on national efficiency and welfare intensified in the aftermath of the 1897 Greco-Turkish war, which Greece lost, and as the population increased after the Balkan Wars (1912–1913), the First World War and the Asia Minor campaign (the latter resulting to the arrival of about 1.3 millions of refugees).[2] Within this context, proponents of social hygiene, including physicians, scholars and politicians, argued that it was imperative to improve the hygienic condition of the population. Although they focused on infectious and childhood diseases, they also set out to combat 'social diseases', a term commonly used in interwar Europe to designate

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[2] Vasiliki Theodorou and Despina Karakatsani, *Hygiene Orders. Medical Supervision and Social Welfare for the Child in the First Decades of the Twentieth Century* (Athens: Dionikos, 2010) (in Greek).

widespread infectious diseases like tuberculosis and venereal disease, as well as alcoholism, drug addiction and insanity, epilepsy and mental retardation.[3] The anxiety over 'social diseases' in the interwar period reflected a rising concern over the health of the family, the nation and the race. All over Europe, state and medical authorities turned their attention not only to the quantity but also to the quality of the population, promoting hygienic and eugenic measures.[4]

In addition to being regarded as a social disease, mental illness was seen as a consequence of other social diseases, either in the same individual or in his/her offspring. Therefore, a way to prevent it was to avert the victims of social diseases from having children, and indeed, many social hygienists supported eugenic birth control through prenuptial examination and certification. However, there was no agreement as to how this should be implemented. Should it be voluntary or obligatory? Should those diagnosed with a social disease be banned from marrying, sterilised, or simply informed of the dangers and be given the option of sterilisation? Some social hygienists opposed certification altogether, arguing instead for improving prospective parents' health and providing proper medical care during pregnancy and labour, as well as family allowances, pregnancy leaves, information on hereditary diseases and education on child care, mainly on breastfeeding, nutrition and hygiene.[5]

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[3] Sevasti Trubeta, *Physical Anthropology, Race and Eugenics in Greece (1880s–1970s)* (Leiden: Brill, 2013), 223.

[4] For an overview of these developments, see Mark Mazower, *Dark Continent: Europe's Twentieth Century* (New York: AA Knopf, 1999), Chapter 3. For social hygiene and social illnesses in other countries of Southeast Europe, see Željko Dugac, "'Like Yeast in Fermentation': Public Health in Interwar Yugoslavia," in *Health, Hygiene and Eugenics in Southeastern Europe to 1945*, eds. Christian Promitzer, Sevasti Trubeta, and Marius Turda (Budapest: Central European University Press, 2010), 193–232 (210, 231) and Gergana Mircheva, "Marital Health and Eugenics in Bulgaria, 1878–1940," in ibid., 235–96 (236 and 247). In France, social hygiene and especially the fight against tuberculosis provided a model for mental hygiene, as evidenced by the foundation of 'dispensaires d' hygiene mentale et sociale' in the 1920s and 1930s. Nicolas Henckes, "Réformer la Psychiatrie, Organiser les Pratiques de Secteur. La Construction de la Psychiatrie de Secteur dans 'l' Experience du Treizième Arrondissemet'" (Convention MiRe, MiRe/INSERM/CNRS, 2005), 51–55.

[5] Eugenics infiltrated medical and political discussions in Greece in the first decades of the century and was closely connected with social hygiene. Their main distinction was that social hygiene did not connect the protection and promotion of health with the individual's biological and cultural value. The most known proponents of social hygiene and eugenics were the obstetrician Moisis Moiseidis, the dermatologist and veneorologist Nikolaos

While eugenic birth control was contested and remained unrealised during this period, education as a preventive strategy was both more widely accepted and implemented. 'Propaganda' or 'enlightenment' on social hygiene through publications, lectures and radio broadcasts was undertaken by public and private agents, such as the Social Hygiene Department of the Ministry of Hygiene, the National Council of Greek Women, which established a Department of Social Hygiene and the book series 'Library of Social Hygiene', and the Patriotic Foundation for Social Protection and Welfare (PIKPA), which, with increasing state funding, established antenatal and child care counselling stations in Athens and other cities. The stations distributed milk for infants and provided pregnant women and mothers with advice on pregnancy hygiene, infant care and child-rearing, aspiring to the ideal of 'scientific motherhood'.[6] Less widespread were institutions giving child-rearing advice from a mental health perspective, such as the 'psycho-pedagogical centres' founded between 1929 and 1932 in Athens by the mathematician and Adlerian psychologist Dimitrios Moraitis.[7]

Clearly, childhood and motherhood were number one targets in social hygienists' endeavour to strengthen the health and well-being of the nation. Childhood was acknowledged as the time when the foundations of health were laid, and mothers as the principal receivers of advice on 'puericulture', namely on how to grow physically and mentally robust children.[8] However, school was also seen as an important locus

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Drakoulidis and two paediatricians with prominent positions in the public health sector during the interwar period, Apostolos Doxiadis and Kostis Charitakis. See Sevasti Trumbeta, "Eugenic Birth Control and Prenuptial Health Certification in Interwar Greece," in *Health, Hygiene, and Eugenics*, eds. Promitzer, Trumbeta, and Turda, 271–98 and Vasiliki Theodorou and Despina Karakatsani, "Eugenics and Puericulture: Medical Attempts to Improve the Biological Capital in Interwar Greece," in *Health, Hygiene, and Eugenics*, eds. Promitzer, Trumbeta, and Turda, 299–324.

[6] Vasiliki Theodorou, "Changing Frameworks of Affinity Between Volunteers, Experts and the State: The Example of Patriotic Foundation of Child Protection," in *Forms of Public Sociality in Twentieth-Century Greece*, eds. Efi Avdela, Charis Exertzoglou, and Christos Lyrintzis (Rethymno: University of Crete, 2015), 82–100 (in Greek).

[7] Lena Atzina, *The Long Introduction of Psychoanalysis in Greece* (Athens: Exadas, 2004), 58–63 (in Greek).

[8] Theodorou and Karakatsani, "Eugenics and Puericulture."

of (mental) health promotion. In 1908 the Ministry of Education established the School Hygiene Service, and school doctors were assigned with assessing the students' physical and mental health and development. Although focusing on body measurements, vaccinations and nutrition, school hygiene also addressed intelligence and mental fatigue in an effort to detect and treat promptly mental problems,[9] while a counselling station for nervous, difficult and abnormal children was founded by PIKPA in the Student Polyclinic of Athens in 1932.[10]

With the students' health being increasingly monitored, concerns about children who could not adjust to mainstream schooling heightened, leading to the founding of the first special school in 1937. Its founder and first principal, the pedagogue Rosa Imvrioti, argued in 1940 that special education could prevent mental illness and crime. She noted that there was an 'army' of children whose bad heredity was intensified by adverse social and familial circumstances, resulting in abnormal mental development and inability to adjust to society. If, along with proper medical care, they received an education adjusted to their needs, their mental and moral capabilities could be restored, their bad tendencies prevented and their disorders corrected. Imvrioti claimed that a calm, loving and physically and morally healthy educational environment, where teachers provided appropriate instruction with patience and understanding, could reform 75% of the abnormal and retarded children to healthy and useful members of society. Within this context she suggested that the state found special schools instead of mental hospitals and prisons.[11] However, the school she founded remained the only public special school up to the 1970s, and was complemented only by a few private ones.[12]

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[9] Theodorou and Karakatsani, *Hygiene Orders.*

[10] Moisis Moiseidis, "The Medico-pedagogical Counselling Stations. Their Scientific Basis, Aims and Organisation," *The Child* 12, no. 80–81 (1941): 3–6 (in Greek).

[11] Rosa Imvrioti, "Abnormal and Retarded Children," *The Child* 11, no. 65 (1940): 6–7 (in Greek).

[12] Dimitrios Stasinos, *Special Education in Greece. Concepts, Institutions and Practices. State and Private Initiative (1906–1989)* (Athens: Gutenberg, 2001) (in Greek).

The Second World War: Moving Towards the Psychological

Evidently, in the first decades of the twentieth century mental illness prevention was not addressed independently but within broader discourses of social hygiene, including school hygiene, eugenics, puericulture and education. Within this context and barring few exceptions, physical factors and their effect on mental health were given more attention than psychological ones. Things started to change during the Second World War, as Imvrioti's ideas already manifested. In 1940, the year that Greece joined the war, the first Greek mental hygiene organisation was founded—the Greek Association for Mental Hygiene. The next year the journal *The Child*, issued by the General Society for the Protection of Childhood and Adolescence, published two articles on mental hygiene and child guidance by the obstetrician and eugenicist Moisis Moiseidis. The first described mental hygiene as 'the branch of hygiene that aimed at the prevention of mental disorders [...] and the preservation, improvement and strengthening of the mental balance of the individuals and the society', and called for the establishment of mental hygiene services in Greece.[13] The second article focused on child mental hygiene, arguing that 'true mental prophylaxis should address the CHILD [emphasis in the original]', and went on to describe the 'medico-pedagogical counselling stations' of Austria and Germany, France, Switzerland and the USA. Blending social hygiene, eugenics and child guidance, Moiseidis proposed a close supervision of children's physical and mental health, and the restriction of harmful hereditary and environmental factors, including parental syphilis and alcoholism, the breaking up of the family, parental violence and the lack or excess of affection. Despite his eugenic background, Moiseidis quoted an American expert who asserted that 89% of abnormal children were victims of factors other than heredity, and therefore that good results could be achieved by improving their social and moral environment.[14]

The increased interest in child mental hygiene, child guidance, and the psychosocial stability of children, was related to rising anxiety in regard to the effects of the war. It was feared that even strong

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[13] Moisis Moiseidis, "For the Mental Health of Our People," *The Child* 12, no. 79 (1941): 4–5 (in Greek).

[14] Moiseidis, "The Medico-pedagogical Counselling Stations."

children became illness-prone when faced with the war's psychosocial repercussions—for example, if they lost one or both parents or experienced poverty, sadness and fear. As a result, the idea that children needed special mental health protection became more widespread. For example, in 1941 PIKPA founded the Department of Mental Protection of the Child, which aimed at balancing the negative wartime experiences and feelings with cheerful and appropriate entertainment through films, radio programmes and games. The Department also aspired to study the mental health problems of childhood, proposing solutions and educating society and the family, mostly mothers, as to how to give children courage, joy and optimism.[15]

The Department was headed by the neurologist-psychiatrist Konstantinos Katsaras,[16] but was grounded less on a specific neuropsychiatric theory than on a general perception that children needed a safe and happy psychosocial environment. Katsaras himself articulated his discourse more in political and social than psychiatric terms. He linked mental illness with what he considered as the hereditary nervousness and pessimism of the Greek race and with the traumatic effects of the war, and supported a broad course of action to prevent mental illness and halt racial decline. This included eugenic, education and social welfare measures (such as premarital certification, education of the abnormal children and popularisation of mental hygiene), professional, social rehabilitation and family support programmes, as well as the strengthening of optimism and love, the fight against pessimism (a mission similar to the one of the Department of the Mental Protection of Children) and the cultivation of religious and nationalist ideas. The latter were anti-communist and guaranteed by the Metaxas dictatorship, with which Katsaras cooperated, especially in the framework of the regime's National Youth Organisation. In sum, while explicitly part of a mental hygiene project, emphasising childhood and youth, Katsaras' view of mental illness prevention was in line with interwar social hygiene and eugenics.[17]

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[15] "The Founding of the Department of Mental Protection of the Child," *The Child* 12, no. 75 (1941): 15–16 (in Greek).

[16] Neurology and psychiatry were a unified specialty in Greece until 1981.

[17] Konstantinos Katsaras, *Mental Education of Youth: Contemporary Problems of Mental and Social Hygiene* (Athens, 1949).

PREVENTION IN THE POST-WAR PERIOD: MENTAL HYGIENE (1950S–1970S)

The interest in mental illness prevention became more systematised after the war. To some extent concerns over psychological trauma caused by wartime experiences continued. As late as 1961 the General Secretary of the Ministry of Social Welfare remarked that the Second World War, the German occupation and the Civil War had left a great number of children 'unprotected' and/or 'traumatised', and that childhood and motherhood had to be protected in order to prevent any 'psycho-traumatism', which could have disastrous effects on the individual and society.[18] However, gradually this type of discourse was replaced by concerns over the effects of social change and broader psychosocial factors. In the 1950s an autonomous mental hygiene movement emerged,[19] as younger professionals, aware of contemporary international developments in social psychiatry and child mental health, launched active mental hygiene organisations. The remaining chapter turns to the three most dynamic private mental hygiene agents, and analyses how these, as well as the state, conceived and attempted mental illness prevention between 1950 and 1980.

The PanHellenic Association for Mental Hygiene

The PanHellenic Association for Mental Hygiene was founded in 1956 by the professor of Hygiene at the University of Athens Gerasimos Alivizatos and the neurologist-psychiatrist Georgios Lyketsos. The latter became familiar with social psychiatry while studying in London and

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[18] Eustathios Poulantzas, "The Social Services for the Child and in Particular the Proper Preventive Work Protect Society from Criminality and Lack of Adjustment," *Archives of Hygiene* 11 (October–December 1961): 10–12 (in Greek).

[19] For mental hygiene in interwar North America and Europe see Johannes C. Pols, *Managing the Mind: The Culture of American Mental Hygiene, 1910–1950* (Ann Arbor: UMI, 2001); Harry Oosterhuis, "Outpatient Psychiatry and Mental Health Care in the Twentieth Century. International Perspectives," in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, eds. Marijke Gijswijt-Hofstra et al. (Amsterdam: Amsterdam University Press, 2005), 248–76; and Mathew Thomson, "Mental Hygiene as an International Movement," in *International Health Organisations and Movements, 1918–1939*, ed. Paul Weindling (Cambridge: Cambridge University Press, 1995), 283–304.

Illinois between 1950 and 1952. In 1952 he became a head psychiatrist at a major psychiatric hospital of Athens, where he played a crucial role in initiating links between patients and their family and community. Looking for ways to make the new social rehabilitation programmes succeed, he acknowledged the need to ‘enlighten public opinion’ and change the public’s attitude towards the mentally ill. To this end he teamed up with the older and esteemed professor Gerasimos Alivizatos, former vice-minister of the Ministry of Health (1936–1938) and founder of the National Association for Epilepsy. They brought together the first members of the PanHellenic Association for Mental Hygiene, including physicians, psychiatrists and pedagogues, but also government and Church officials, and established strong international contacts: they participated in the yearly meetings of the World Federation of Mental Health, of which Alivizatos was president in 1963–1964, and organised the 15th Meeting of the European Association of Mental Hygiene in Athens in 1965.

The Association aspired to instigate a reform of the psychiatric law, which dated from 1862, and several of its members participated in the committee that under Alivizatos’ presidency prepared a psychiatric bill in 1959 (which did not become law). Besides this, the Association’s work mainly focused on three fields: mental health education via radio broadcasts, lectures, screening of films, and events like the Week of Mental Health, which took place in 1962; training of professionals with mental hygiene seminars; and parents’ education through a parents’ school in Athens. In addition, the Association undertook research on issues such as the mental health of factory workers and families of immigrants, and the attitudes of families towards mentally ill members.[20]

The Association’s publications demonstrate its interest in and concepts of prevention. In 1959 Alivizatos stressed that prevention was less expensive than treatment. He argued that ‘prophylactic institutions’ were necessary, which could help the normal development of the personality and the adoption of a healthy social conduct. He justified the need for preventive measures in two ways: first, mental illnesses were increasing due to the sudden social, economic and ethical changes caused by the wars, as well as the accelerated rhythm of modern life; second, mental illnesses were difficult to treat. In contrast to the severest infectious

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[20] Georgios Lyketsos, *The Novel of My Life* (Athens: Gavriilidis, 1998), 287–317 (in Greek).

diseases, mental illnesses had not been combated and were more dangerous, as they were often chronic and they affected not just the patients but also their family and wider social environment. Alivizatos was not endorsing a radical social psychiatry stance; he did not believe that mental health professionals could solve the political, social, economic and ethical problems that affected the mental health of a whole people. However, he argued that mental hygiene could offer guidance as to 'how we will aim at keeping our mental health in our increasingly agitated and exceptionally stormy life'.[21]

A few years later, in 1962, the other founder of the Association provided a more precise, though all-encompassing, idea of what prevention was and how it could be achieved. Lyketsos adopted the concept of primary, secondary and tertiary prevention, namely the prevention of occurrence, progress and relapse of mental illness, thus presenting the whole of psychiatry as preventive. Primary prevention, which concerns the present analysis, was conceived as the limitation of the impact of traumas, which stemmed not from war experiences, but from the biological, social and psychological conditions of life. For example, embryos could be traumatised by poor nutrition and inadequate medical care during pregnancy; infants by maternal deprivation; young children by the breaking up of the family. Concentrating on psychosocial traumas, Lyketsos argued that their extent and impact could be curtailed in a sound psychosocial environment, which would balance disappointing and satisfying experiences. He understood parenting as a major agent of prevention, but parents as either ignorant of 'modern medical knowledge', or unable/unwilling to apply it. Parents, and in particular mothers, had to know and adjust to the changing psychological needs of the developing child. They needed to be instructed—ideally in parents' schools like the one the Association founded—in a series of issues, from how to hold and feed the baby to how to handle gender differences and help children develop effective mechanisms for channelling their urges. The goal of prevention could also be furthered by medico-pedagogical centres and mental hygiene units, and through the support of physicians and psychologists, social workers and nurses, parents, teachers and priests, the upper strata of the educated and professional classes and politicians. Most importantly, doctors in rural areas, where mental health

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[21] Gerasimos Alivizatos, "Mental Health Around the World Today and Mental Illnesses," *Archives of Hygiene* 9, no. 4–6 (April–July 1959): 27–41 (in Greek).

institutions were scarce, should observe the population, disseminate the principles of mental hygiene and influence child-rearing. To this end, they had to be trained in mental hygiene and cooperate with mental health professionals.[22]

The Society for the Mental Hygiene and Neuropsychiatry of the Child

The Society for the Mental Hygiene and Neuropsychiatry of the Child was founded in 1957 by psychiatrists, psychologists, special education professionals and social workers. It aimed at 'a) the study, research and promotion of the mental health of the child, of child neuropsychiatry, psychology and special education, and b) the pursuit of the practical applications of the above-mentioned scientific disciplines for the good of society'.[23] It undertook research and educational activities, addressing mainly professionals through presentations and seminars, and to a lesser extent the general public through open lectures. The Society communicated with foreign professionals, and became a member of the International Association of Child Psychiatry and Allied Professions in 1963.[24]

The initiative for founding the Society was assumed by the neurologist-psychiatrist Andreas Kaloutsis, who was only a few years older than Lyketsos and had received training in France (psychiatric hospitals of Sainte Anne and Hôtel-Dieu in Paris) and the USA (Medical School of the University of Texas in the early 1950s). He played a pivotal role in the organisation of the field of child mental health in Greece during the late 1950s and the 1960s. Not only did he form the Society, which helped to bring together the interested professionals and establish them as experts; he also participated in the committee for the reform of mental health legislation in the late 1950s, he repeatedly supported the recognition of child psychiatry as a distinct specialty (which materialised in 1962), and became one of the first child psychiatrists in Greece (1967). Additionally, he provided an integrated model for child mental health care, based on different types of services: children's neuropsychiatric

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[22] Georgios Lyketsos, "The Prevention of Mental Illnesses," *Archives of Hygiene and Medical Information* 16, no. 3 (July–September 1966): 257–61 (in Greek).

[23] Aspasia Kaloutsi, *The Greek Society of Mental Hygiene and Neuropsychiatry of the Child: 35 Years. A Review* (Athens: Ellinika Grammata, 1993), 19 (in Greek).

[24] Ibid., 39.

hospitals (the first was founded in Athens in 1958 and Kaloutsis was its first director), medico-pedagogical and vocational guidance services, special schools and classes, and asylums for the incurable.[25]

Kaloutsis envisioned child psychiatry as an essentially preventive branch of psychiatry, seeing it as vital for the prevention of mental illness,[26] and, consequently, for the 'sanitisation of the Nation'.[27] Among the different types of child mental health care services, he perceived medico-pedagogical centres as central loci of prevention. In collaboration with other professionals, who later became members of the Society, he founded the first such centre in Greece. Operating between 1953 and 1955 in the framework of the Educational Society 'Athineon', the centre aimed at:

> [t]he timely prevention of those trivial 'nothings' [e.g. problems in eating and sleeping, jealousy, stubbornness and disrespect] that often lead to severe neuroses, [and] the fight against ignorance of and prejudice against the neurologists, psychiatrists, psychologists […] to whom people turn when it is irredeemably late […].[28]

This centre, and the ten approximately similar public and private centres founded in the next decade, mainly in Athens and Thessaloniki, followed the model of child guidance clinics, aiming less at the mentally ill and more at difficult and neurotic children.[29] The centres' practice was based on the premise that prevention was easier in childhood and early life, and that it was possible to deter secondary behavioural disorders

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[25] "Subcommittee for the Legislation on Children and Adolescents' Mental Hygiene. Conclusions, 10/4/1957," folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi.

[26] "Sketch of Activities of the Ministry of Social Welfare for the Year of Mental Health," folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi.

[27] "Memo to her Excellency Mrs. Minister of Social Welfare. Topic: The Mentally Ill Child," folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi.

[28] Ioanna Kolokouri, "For Children with a Difficult Character," newspaper clipping, folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi.

[29] On child guidance's preventive idea of treating the 'everyday child' and his/her 'ordinary troublesome behaviour' see Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge, MA: Harvard University Press, 1999) and John Stewart, *Child Guidance in Britain, 1918–1955* (Abingdon, Oxon: Pickering & Chatto, 2013).

and failure in school and professional life, as well as major disorders in childhood and adulthood, if minor emotional and behavioural problems in childhood were treated promptly with special education and supportive psychotherapy. Preventive work was also directed towards the children's immediate environment. Parents and teachers were familiarised with mental hygiene and child psychology, and helped to understand and handle the children's needs and problems. Finally, seeing children's difficulties as inextricably linked with parents' attitudes, medico-pedagogical centres offered group and individual counselling, and sometimes psychotherapy to parents whose children they treated.[30]

Apart from the establishment of child psychiatry and medico-pedagogical centres, Kaloutsis regarded as preventive the provision of 'useful entertainment' to children, for example films, plays and sport; the collaboration of parents and teachers with mental health professionals; the development of the practice of foster families; the provision of parents' education programmes; and even eugenics measures in terms of enlightenment on the suitability of marriage, and on the hygiene of pregnancy and infancy.[31] At the same time he adopted the perspective of social psychiatry that placed less emphasis on heredity and more on the social environment, and argued that the 'most radical measure' of prevention was to remove every pathogenic social factor. He seemed to endorse the idea that psychiatrists were able to solve the problems of social adjustment that caused mental illness, and thus they should stop being isolated in hospitals and acquire an active social role.[32] However, the Society did not attempt such an ambitious goal, but limited its preventive endeavours to informing professionals, teachers and parents on childhood and adolescence problems, child rearing and education.

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[30] Despo Kritsotaki, "Mental Hygiene and Child Guidance in Post-war Greece: The Case of the Centre for Mental Health and Research, 1956–1970," *Social History of Medicine* 27, no. 4 (2014): 751–67.

[31] "Subcommittee for the Legislation on Children and Adolescents' Mental Hygiene" and "Sketch of activities of the Ministry of Social Welfare for the Year of Mental Health." The persistence of eugenics is also indicated by the publication of articles in the official journal of the Ministry of Health in the 1950s and early 1960s that supported the idea that marriage should be avoided or prohibited for those with hereditary illnesses. For example Antonios Papadakis, "Mental Health and Mental Retardation of Children. A Problem of Public Hygiene," *Archives of Hygiene* 8, no. 4–6 (1959): 86–106.

[32] Andreas Kaloutsis, "Social Psychiatry," folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi.

The Centre for Mental Health and Research

The psychologist Anna Potamianou founded the Centre for Mental Health and Research in 1956. Her studies in Paris and her collaboration with other professionals who had studied in Britain and the USA informed the Centre's practice with new tendencies in psychodynamic and social psychiatry. Like the two previous organisations, the Centre implemented research and education programmes, but it also established clinical services: initially a medico-pedagogical centre and a vocational guidance service, and a few years later a counselling psychiatric service for adults in Athens. In addition, the Centre was in charge of four social welfare services in Athens, Piraeus, Patrai and Thessaloniki, the Social Aid Stations. More services were to follow in the late 1960s, when the Social Aid Stations of Piraeus and Thessaloniki were converted to Social Psychiatry Services, and in the 1970s, when two new medico-pedagogical centres were founded. The Centre's staff included Kaloutsis and other members of the Society for the Mental Hygiene and Neuropsychiatry of the Child.[33]

For the Centre, mental hygiene was 'a relatively new scientific branch' aiming at the prevention and suppression of mental illness. For the purposes of prevention, the Centre was committed to 'the wide dissemination of the principles of mental hygiene' through programmes for professionals, the general public and special groups (parents, priests, teachers, rural communities officials and police officers), and to 'the founding of counselling and vocational centres', where 'every day problems are handled and difficulties arising in interpersonal relations are smoothed'. Therefore, prevention was attempted through the training of professionals and the 'enlightenment' of the public, which would ensure the timely detection of mental health problems, as well as prompt intervention in minor difficulties, which could avert more serious mental disorders.[34] In addition, research on the reasons why some groups, such

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[33] For a short history of the Centre, see Despo Kritsotaki, "Initiating Deinstitutionalisation: Early Attempts of Mental Health Care Reform in Greece, 1950s–1970s," in *Deinstitutionalisation and After. Post-war Psychiatry in the Western World*, eds. Despo Kritsotaki, Vicky Long, and Matthew Smith (Cham: Palgrave Macmillan, 2016), 155–72.

[34] Programmes for professionals included a seminar on preventive psychiatry and the prevention of suicide in 1971, and a conference on preventive psychiatry in 1979. Royal National Foundation, *Mental Hygiene Section, December 1956–December 1963* (Athens, 1964) (in Greek). Quotes from pp. 3 and 5.

as women, were more vulnerable to mental illness, was meant to help curtail mental illness by highlighting the social conditions leading to it, and instigating their modification.[35]

Much of the Centre's prevention work concentrated on child mental health, through relevant research and educational activities, work in the medico-pedagogical centres and cooperation with schools, nurseries and orphanages. However, broader issues of prevention were addressed in events like the two-day seminar on 'problems of adult life' headed by Kaloutsis in 1965 in Patrai. The topics discussed included various aspects of work, marriage, family and social relationships.[36] Such events were part of a larger community programme, which aimed at locating and addressing the needs of communities, even if help was not asked for, and at affecting social policy, especially in poor neighbourhoods.[37]

While the Centre's prevention programmes were grounded to a great extent in social psychiatry, a biological orientation began to manifest at the end of the 1970s. The international conference on preventive psychiatry organised by the Centre in 1979 featured papers on genetic–biological models of prevention along with psychosocial ones. As the psychiatrist Georgios Christodoulou, president of the conference and member of the Centre's administration board, stressed in his opening speech, social psychiatry was historically at the core of mental illness prevention, but 'during the last years the concepts of psychiatric prevention also include psychiatric genetic counselling and biological (and in particular psycho-pharmaceutical) psycho-prophylaxis'.[38]

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[35] Centre for Mental Health and Research, *An Epidemiological Study on Mental Health. The Findings* (Athens, 1976), 99–101.

[36] Andreas Kaloutsis, "Problems of Adult Life Seminar in Patrai. Sketch of the Seminar," folder Andreas Kaloutsis, archive of Aspasia Tavlaridou-Kaloutsi (in Greek).

[37] Rita Papatheofilou and Markos Kozadinos, "Experience of the Medico-pedagogical Service of the Centre for Mental Hygiene of Piraeus," archive of Markos Kozadinos (in Greek). The authors referred to Gerald Caplan's *An Approach to Community Mental Health* (London: Tavistock, 1961) and to the community work dilemma he presented: should help be given to those who ask for it, and who might not need it as much, or to those with the gravest problems, who often do not know the existing mental health services or resist their help?

[38] Centre for Mental Health, *Conference of Preventive Psychiatry, Programme* (Athens, 1979) (in Greek).

Prevention and the State

Prevention as conceived and implemented within the mental hygiene movement was based on private initiatives. State officials occasionally acknowledged the need for mental illness prevention, especially during childhood,[39] and invested prevention with national importance: the creation of healthy and productive individuals would guarantee the progress of the country and annihilate the negative elements leading to antisocial behaviour and crime.[40] Within the authoritarian regime of post-civil-war Greece, mental health promotion was perceived as a means for securing that 'the enemies of the Homeland [i.e. communists] will not find conducive ground to develop their corrupting for the Nation activities'.[41]

To some extent governmental visions of prevention concurred with mental hygiene ideas and practices: enlightenment by scientific organisations was deemed important,[42] and papers on mental hygiene were published in the official journal of the Ministry of Health. Some public funding was provided for private sector research and services, and renowned professionals working in state or private settings were occasionally asked for expert opinion on mental health policy. For example, as already mentioned, Alivizatos and Kaloutsis participated in the legislative committee that in 1959 proposed a new psychiatric law, which emphasised prevention, for instance through the establishment of medico-pedagogical centres.[43]

However, the state did not fully endorse mental hygiene. Official discourses and programmes were haphazard and tied to older and/or non-psychiatric approaches: the perception of mental illness as a social illness that could be prevented through education and advice on physical hygiene, for example in mother and infant centres[44]; eugenic birth

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[39] Andreas Stratos, "Speech on Mental Hygiene in Greece," *Archives of Hygiene* 8, no. 4–6 (January–March 1959): 25–26 (in Greek).

[40] Poulantzas, "The Social Services for the Child."

[41] Ioannis Psarreas, "Opening of the Seminar for the Staff of Psychiatric Hospitals," *Archives of Hygiene* 8, no. 10–12 (October–December 1959): 549–54 (553) (in Greek).

[42] Ioannis Psarreas, "Mental Illnesses and Mental Hygiene," *Archives of Hygiene* 8, no. 4–6 (January–March 1959): 23–24 (in Greek).

[43] Psarreas, "Opening of the Seminar for the Staff of Psychiatric Hospitals."

[44] Poulantzas, "The Social Services for the Child."

control[45]—indeed an obligatory prenuptial health certification was instituted in 1968 by the military dictatorship (1967–1974)[46]; the cultivation of the Christian sentiments of love, interest and understanding for fellow people[47]; and the protection of children from inappropriate and immoral stimuli, such as books and films that frightened children or presented 'wrong' examples.[48] State support to mental hygiene was limited: the suggestions of mental hygienists were not acted upon—most notably, the 1959 bill was not passed—and, apart from a few public medico-pedagogical centres founded in the 1950s and 1960s, and the occasional organisation of enlightenment events, like lectures and film screenings, mental hygiene remained marginal in public policy.

In 1969 the Director of the Hygiene Section of the Ministry of Social Services admitted that not much had been done in terms of mental illness prevention. He attributed the scanty achievements of mental hygiene to the lack of legislative provision for prevention and to the public's reluctance to cooperate, arguing that 'the lower social classes and mostly the rural population' conceived of mental health in terms of madness and seclusion in hospitals. He claimed that the new

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[45] Christos Agoropoulos, "The Social Hygiene Section," *Archives of Hygiene* 1, no. 10–12 (October–December 1950): 439–48 (in Greek).

[46] Obligatory Law 300 "On the Prenuptial Certificate of Medical Examination," *Government Gazette* 42, a (27 February 1968) (in Greek). The law was not defining instances in which marriage was prohibited, and soon obtaining the certificate became a bureaucratic, rather than medical and hygienic, process. After the fall of the dictatorship in 1974 the law was judged unconstitutional and was abolished. Discussions on premarital health examination and certification continued, but were disengaged from social diseases and racial decline and considered individual rights (Trubeta, *Physical Anthropology*, 270–71). The 1980 law on family planning (Law 1036 "On Family Planning and Other Provisions," *Government Gazette* 66, a (21 March 1980) (in Greek), indicates that eugenics was being transformed, mixing with ideas of reproductive health, as had happened earlier in other countries (Erika Dyck, "Newgenics and the Politics of Choice: A Historical Look at Canada's Psychiatric Institutions in the 1970s," in this volume).

[47] Psarreas, "Mental Illnesses and Mental Hygiene."

[48] Ioannis Papageorgiou, *The Social Protection of the Child in Greek Legislation* (Athens: National Centre of Social Research, 1972) (in Greek). The effect of reading material and the mass media on the minds and souls of children and youths had attracted the interest of mental health professionals in the post-war period (see Dennis Doyle, "Imagination and the Prevention of Violence: Fredric Wertham, Mass Media, and Mental Hygiene, 1946–1958," in this volume). However, in the case of Greece, the references to such inappropriate stimuli were not based on any professional opinion or research, but mostly reflected a conservative, common sense ethic.

mental health bill that was being prepared included an important mental hygiene programme based on the contemporary international models.[49] The law passed in 1973, despite the problematic continuation of compulsory confinement in mental hospitals, mentioned prevention among the aims of psychiatric services, and allowed for voluntary admission and the establishment of mental hygiene centres for the psychobiological study of children and adolescents, which could gradually be complemented by medico-pedagogical centres. Still, the law did not bind the state to found any of these.[50] It was only in 1983, with the establishment of the National Health System, that mental hygiene centres were founded for 'psychosocial welfare, community counselling intervention and enlightenment, prevention, treatment and contribution to rehabilitation'.[51]

Conclusion

As the case of twentieth-century Greece exemplifies, ideas and practices of mental illness prevention were constantly related to social anxieties and the goals of social progress and stability, which were given different meanings by different agents and in different times. The interwar dictatorship and the post-civil-war authoritarian regime conceived of mental illness prevention as a way to strengthen nationalism and anti-communism. During the post-war years this concept of prevention became less widespread and was mostly found in official state discourses. Mental health professionals focused on the psychological balance of the individual and the change of or compensation for adverse social conditions, which affected individuals and communities.

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[49] Vasilios Derdemezis, "Report on the Work of the Ministry of Social Services, Section of Hygiene," *Archive of Hygiene* 19, no. 3–4 (July–December 1969): 173–345 (221) (in Greek).

[50] Legislative Degree 104/73 "On the Mental Hygiene and Welfare of the Mentally Ill," *Government Gazette* 177, a (16 August 1973) (in Greek) and "On the Application of the Article 4 of the Legislative Degree 104/73," *Government Gazette* 1523, b (31 December 1973) (in Greek). This legislation was criticised after the fall of the dictatorship for various reasons, mainly for violating human rights (Sotirios Kotsopoulos, "Greek Legislation on Mental Hygiene. A Critical View," *Political Issues* 42 (3–9 May 1975) (in Greek)) and was amended in 1978.

[51] Law 1397 "National Health System," *Government Gazette* 143, a (7 October 1983): article 21 (in Greek).

This change was part of a broader mid-century shift in prevention models from predominately biological to psychosocial. In the early part of the twentieth century, when concerns over public health and national efficiency were prominent, mental illness prevention was part of social hygiene, and placed more emphasis on biological issues. Social hygienists supported eugenic measures, and even their environmental approaches linked to physical factors, such as the improvement of nutrition for pregnant women and infants, and the vaccination of children. During and after the Second World War, with the intensification of worries over psychological trauma caused by wartime experiences and modernisation, mental illness prevention was predominately addressed within the mental hygiene movement, which incorporated theories of social psychiatry. Even though social hygiene and eugenics did not cease to be discussed as a path to prevention, and a eugenically inspired law was passed as late as 1968, support for eugenics was weak; the interest had shifted to psychosocial aspects, such as maternal deprivation, family breakup, and, for more radical professionals, more general adverse socio-economic conditions. The dominance of social psychiatry was challenged by biological/genetic models only at the end of the 1970s.

The emergence of new ideas and practices of prevention since the 1940s and chiefly the 1950s was made possible by changes in the professional landscape of mental health: new professionals (child psychiatrists, psychiatrists interested in social psychiatry, psychologists, social workers, special educators) articulated new claims for their scientific and social role and for the reorganisation of the mental heath system. However, as in the first part of the century, mental illness prevention had a limited impact. Among the broad range of ideas those that achieved most consensus and were more likely to be implemented were ‘enlightenment’ and prevention in childhood (including infancy and adolescence), which was persistently thought of as more vulnerable and simultaneously more amenable to preventive actions.

To some degree, the restricted realisation of prevention initiatives was due to the fact that they stemmed mainly from the private sector and lacked public/state support. Apart from a general and theoretical support to mental hygiene, the state only undertook meagre prevention policies. However, even in countries like the USA, where mental hygiene and child guidance had been more widely supported and implemented in the 1920s and 1930s, and where prevention had attracted much interest between the 1950s and 1970s, dissatisfaction with the content and results of these programmes was also manifest. The proponents of prevention were divided between those who called for specific measures and those who called for broader political and social change; programmes lacked a generally accepted scientific basis, as the aetiology of mental illness remained unspecified; and mental health policies usually ended up prioritising treatment over prevention in practice.[52] Within this context, it appears that Greece was not an exceptional, but rather a more extreme case of problematic prevention policies. Thus, the analysis of discourses and practices of mental illness prevention in twentieth-century Greece reinforces the view of prevention in mental health as a particularly difficult and contested enterprise moving in slippery ground.

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[52] Spaulding and Balch, "A Brief History of Primary Prevention." As the authors indicate, in child guidance clinics, which were designed as preventive services, remedial functions soon outweighed the preventive functions. Similarly, due to the lack of diverse and sufficient services for children, Greek medico-pedagogical centres were asked to treat already developed problems, commonly diagnosed as 'mental retardation' and 'childhood psychosis' (usually meaning autism).

CHAPTER 6

Socialism, Society, and the Struggle Against Mental Illness: Preventative Psychiatry in Post-war Yugoslavia

Mat Savelli

INTRODUCTION

Even by the standards of the time, Yugoslavia's experience of the Second World War proved exceptionally brutal. Over a half decade, the country was torn apart, with borderlands parcelled out to surrounding states while the forces of fascism, both domestic and foreign, engaged in campaigns of deportation, forced migration and extermination of local populations. The resistance, meanwhile, had been severely fractured, with vicious fighting between groups pushing for the reestablishment of the interwar monarchy and others who marched under Josip Broz Tito, the secretary general of the Yugoslav Communist Party and leader of the self-styled National Liberation Army. Tito's partisans were ultimately victorious, expelling and extinguishing their rivals with relatively little assistance from foreign armies. In the process, Yugoslavia was reborn as the Federal People's Republic of Yugoslavia (later the Socialist Federal Republic of Yugoslavia), one of a number of states across Eastern Europe that

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sought to reorient government and society towards the establishment of Communism.

Among the greatest challenges facing the country's new post-WWII (Second World War) government was the population's dire health situation. The destruction of infrastructure and housing, the disruption of food supply, and vast internal displacement had created a perfect storm for malnutrition and the spread of infectious diseases. Outbreaks of typhus, malaria, dysentery, diphtheria and tuberculosis (among other diseases) reflected the scope of the problem. Moreover, the war years had strained people's psychological resources as peasants and urbanites alike faced unspeakable violence amidst a complex situation of revolving political allegiances and threats.[1] As part of their wider attempt to refashion Yugoslav society, the government and loyal medical authorities initially proposed a Sovietisation of the health care services to bring the crisis under control. Leading medical journals, at least in the period before Tito's fateful 1948 break with the Soviet bloc, were replete with editorials testifying to the greatness of the Soviet medical services, contrasting health care within the USSR with that of the West, where health was 'bought and sold.'[2] Among the major foci of these early editorials was the notion that the construction of truly socialist health care could only happen along prophylactic lines. These writers stressed the need to engage in 'health enlightenment' work to transform the beliefs and behaviour of the largely rural society; such a transformation was needed to ensure the survival of the newly established Communist state.[3] These doctors framed themselves as chief architects in the construction of socialism, with a clear responsibility to educate the masses about health

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[1] For elaboration on the impact of the war on people's mental health, see the excellent descriptions found in Ana Antic, *Therapeutic Fascism: Experiencing the Violence of the Nazi New Order* (Oxford: Oxford University Press, 2016).

[2] Among others, see N. Nikolic, "Vladimir Iljic Lenjin i Zastita Narodnog Zdravlja," *Medicinski Glasnik* 1, no. 5 (1947): 85; G. Nikolic, "Oktobarska Revolucija I Razvoj Sovjetske Medicine," *Vojno-Sanitetski Pregled* 4, no. 11–12 (1947): 208–211; V. Stojanovic, "Velika Oktobarska Revolucija i Zastita Narodnog Zdravlja USSSR," *Medicinski Glasnik* 2, no. 2 (1947): 23.

[3] Anon, "Osnovi Principi Nase Zdravstene Sluzbe," *Medicinski Glasnik* 1, no. 3 (1946): 46; see also the untitled editorial by an unlisted author in *Medicinski Glasnik* 1, no. 1 (1946): 1. For more, see Federal People's Republic of Yugoslavia, *Public Health and Health Service Annual Report 1949–1950* (Zagreb: Council of Public Health and Social Welfare of the Government of the Federal People's Republic of Yugoslavia, 1952).

and 'beat down the culture of hygienic backwardness.'[4] Other factors, especially the wartime destruction of health infrastructure and a dire physician shortage, further incentivised the development of a health care system that would do more to prevent disease, rather than treat it.

Despite the ideological rhetoric of the early socialist years, the attention to preventative medicine was not entirely new to Yugoslavia, and the medical service possessed a rich history in terms of public health. In 1927, the national government and the Rockefeller Foundation had helped establish the School of Public Health and Institute of Hygiene in Zagreb. Under the aegis of Andrija Štampar, the school developed novel approaches that helped reshape ideas about what was possible through public health education, and Štampar's expertise soon became recognised internationally.[5] Among other initiatives, he launched a 'Peasants University' to provide health and hygiene seminars to Yugoslavia's considerable rural population. Although Štampar was forced out of his position in the early 1930s (landing on his feet by finding work with the League of Nations), he helped entrench the necessity for socially engaged approaches to medicine; he later transferred this expertise to the fledgling WHO when he became the first president of the World Health Assembly. This work in the interwar period helped set the stage for the shift towards prophylactic health care in the post-WWII period.

In short, both tradition and the material–political conditions of the mid-late 1940s served to create a climate favourable for the development of preventative medicine in the newly established Federal People's Republic of Yugoslavia (known after 1963 as the Socialist Federal Republic of Yugoslavia). The purpose of this chapter is to analyse the

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[4] Stjepan Policer, "Lekari i Zdrastveno Prosvecivanje," *Medicinski Glasnik* 2, no. 4 (1948): 71.

[5] Štampar has fascinated historians of medicine and the centrality of his role in establishing the social nature of medicine cannot be understated, either within Yugoslavia or more broadly. See Stella Fatovic-Ferencic, "'Society as an Organism:' Metaphor as Departure Point of Andrija Štampar's Health Ideology," *Croatian Medical Journal* 49, no. 6 (2008): 709–19; Zeljko Dugac, *Protiv Bolesti i Neznanja: Rockfellerova fondacija u međuratnoj Jugoslaviji* (Srednja Europa, Zagreb, 2005); Zeljko Dugac, "'Like Years in Fermentation': Public Health in Interwar Yugoslavia," in *Health, Hygiene, and Eugenics in Southeastern Europe to 1945*, eds. Christian Promitzer, Sevasti Trubeta, and Marius Turda (Budapest: Central European University Press, 2011), 193–232; Martin Kuhar, "'From an Impure Source, All Is Impure': The Rise and Fall of Andrija Štampar's Public Health Eugenics in Yugoslavia," *Social History of Medicine* 30, no. 1 (2017): 92–113.

evolution of the psychiatric profession and mental health care during the period of Communist rule, ending with the country's violent collapse in 1991. Drawing upon professional discussions within the subfields of addiction, suicidology and military psychiatry, the chapter reveals how notions of prophylaxis entered into psychiatric discourse, eventually becoming one of the dominant strands of thought within Yugoslav mental health care. Significantly, however, the diffusion of preventative psychiatry did not draw inspiration from the Soviet example, nor did it derive legitimacy from the ideological tenets of Marxism.[6] Instead, Yugoslav practitioners who urged a focus on psychiatric prophylaxis borrowed heavily from British and West European theorists, especially members of the social psychiatry movement. As such, the Yugoslav story can be understood as a significant, but understudied, piece of the wider post-WWII experiments with preventative psychiatry. Ultimately, psychiatric prophylaxis in Yugoslavia would come to centre upon the notion that the whole of society itself could (and must) be engaged and transformed to truly improve people's mental health.

Foundations of Preventative Psychiatry

To understand how the concept of prevention came to occupy such an integral position within Yugoslav psychiatry, it is necessary to consider the post-war experiences of the country's few psychiatrists.[7] Despite the pressing need for physicians of all stripes to attend to the burgeoning

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[6] For readers unfamiliar with the East European context, a significant rupture occurred between Yugoslavia and the Soviet bloc in 1948 after several clashes between Tito and Stalin. Yugoslavia was ultimately expelled from the Cominform (the Soviet dominated umbrella organisation that coordinated Marxist-Leninist parties across Europe) and a period of immense tension ensued as the Soviet Union and its allies declared Titoism as a dangerous heresy. Yugoslavia, fearing both a Soviet-led invasion and/or an internal coup led by Stalinists, rapidly disavowed anything that smacked of Soviet influence. Within the realm of medicine, for example, the near-monthly exaltations of Soviet health care that had peppered journals between 1945 and 1948 immediately ceased; subsequent appraisals of Soviet medicine were largely derogatory. Despite the Tito-Stalin split, the Yugoslav government remained ideologically devoted to the long-term establishment of Communism. In 1953, the country's leaders declared a new and unique roadmap on how to actually achieve this transition, using the slogan 'self-managing socialism.'

[7] Although exact figures are difficult to pinpoint, for roughly 15,000,000 citizens at the conclusion of the war, there were probably no more than two dozen mental health specialists.

crisis posed by infectious disease, the long-term plan to modernise mental health services required that practitioners receive additional training. With very few medical schools and no pre-existing programme of psychiatric specialisation (this was launched only in 1948–1949), practitioners were forced to go abroad. Relying upon pre-existing relationships, Rockefeller grants, and government-sponsored initiatives, practitioners young and old consequently left Yugoslavia to study the techniques of their international colleagues.[8] In a short matter of time, these patterns of temporary migration became entrenched and a period spent studying abroad (largely in Britain, France and the United States) acted as a rite of passage for emerging mental health specialists. During these sojourns, Yugoslav psychiatrists were exposed to a broad diversity of theoretical and clinical approaches, many of which would eventually make their way into Yugoslav medical curricula.

In terms of orienting the psychiatric services towards prevention and social psychiatry, one particular year stands out as remarkable. In 1959, several practitioners who would go on to become highly influential members of the country's psychiatric elite—Vladimir Hudolin and Duska Blazevic from Zagreb, Dusan Petrovic and Slavka Moric-Petrovic from Belgrade, and Lev Milcinski from Ljubljana—simultaneously wound up in London. While there, they were exposed to the ideas of the emerging social psychiatry movement, most notably through Maxwell Jones, Joshua Bierer and Aubrey Lewis.[9] For Yugoslav psychiatry, the London experience of this young cohort of practitioners would prove consequential in laying foundations for preventative mental health care.

Trained at the University of Edinburgh under David Henderson, Maxwell Jones most famously pioneered the concept of the Therapeutic Community, a revolutionary reaction to the hierarchical, stultifying, and oppressive existence that many felt characterised the psychiatric hospital of the early twentieth century. In the 1950s, while based at Belmont Hospital in Surrey (then connected administratively to the Maudsley and Aubrey Lewis), Jones dramatically reconceptualised the workings of the hospital along more egalitarian lines. The members of the Therapeutic

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[8] Details regarding some of the early post-war foreign training initiatives can be found in Ministry of Health files dated 11/02/1946 at the Federal Archive of Yugoslavia, Belgrade. See Vladimir Vujic, "Ministarstvu Narodnog Zdravlja FNRJ," Komitet Za Zastitu Narodna Zdarvlje Vlada FNRJ (Arhiv Jugoslavije: 1946).

[9] Dusan Petrovic, interview with the author. Sept 8, 2007, Belgrade.

Community—physicians, nurses and patients—all worked on a first name basis and a democratic decision-making process guided the running of the hospital. At daily meetings, staff and patients were to come together to make therapeutic and administrative decisions in a climate of free speech. In Jones' eyes, responsibility for treatment was thus not entirely up to staff; patients were themselves active agents in the treatment of one another.[10] Leaving Belmont in 1959, Jones carried on nomadically, criss-crossing the Atlantic to enthusiastically challenge psychiatric tradition and spread the gospel of Therapeutic Communities until his death in 1990 in Wolfville, Nova Scotia. Although historians have paid relatively little attention to Jones, much of his work can be seen as a theoretical antecedent to later radicals like Franco Basaglia, David Cooper, and R.D. Laing.[11] It is perhaps no surprise that, rather than 'a psychiatrist,' Jones was known to characterise himself as a 'social change agent.'[12]

Joshua Bierer, meanwhile, carved out a similarly colourful career, claiming to have 'invented British Social Psychiatry,' although not all of his colleagues shared that impression.[13] Trained in Vienna and deeply influenced by Alfred Adler, Bierer was forced to leave for the UK with the coming of Nazism. In Britain, one of Bierer's more significant innovations was the creation of the Sunny Side Club, a group designed to facilitate patient social interaction, counting both current and past patients as its members. Operating relatively free from institutional and professional oversight (although membership was made up of patients and staff alike), the club would meet weekly, offering opportunities for leisure, discussion, publishing and sport. Bierer also set up exclusively extramural clubs for patients who no longer had any connection to the

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[10] Maxwell Jones, *Social Psychiatry in Practice: The Idea of the Therapeutic Community* (Harmondsworth: Penguin, 1968).

[11] Nick Crossley, "RD Laing and the British Anti-psychiatry Movement: A Socio–Historical Analysis," *Social Science & Medicine* 47, no. 7 (1998): 877–89; Catherine Fussinger, "'Therapeutic Community', Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry After World War II," *History of Psychiatry* 22, no. 2 (2011): 146–63.

[12] David H. Clark, "Therapeutic Community Memories: Maxwell Jones. Planned Environment Therapy Trust," 2005, http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=781:therapeutic-community-memories-maxwell-jones&catid=241&Itemid=407.

[13] Liam Clarke, "Joshua Bierer: Striving for Power," *History of Psychiatry* 8, no. 31. (1997): 319–32. Much of this paragraph is indebted to Clarke's work.

hospital itself. His search for alternatives to the classic psychiatric hospital continued and, in 1946, he opened what eventually became known as the Marlborough in Hampstead. Among the first open-door psychiatric day centres, the Marlborough (like Jones' Belmont Hospital) became the site of experimental forms of institutional organisation. While patients remained in the community, they were expected to make several appearances at the centre each week, partaking in various forms of group-based therapy. Beyond this work, Bierer positioned himself as an important figure in the evolving social psychiatry movement, setting up and editing the *International Journal of Social Psychiatry* and the British Association of Social Psychiatry.

Although the innovations launched by Jones and Bierer related primarily to new forms of treatment, both were part of a wider British scene of the 1950s and 1960s that underscored the social nature of mental illness, arguing that psychiatry needed to move beyond the individual (the focus of both organic and psychoanalytic approaches) and give more consideration to social conditions and relationships. Drawing upon contributions from the social sciences, Aubrey Lewis (his own work often cited by Yugoslav practitioners, many of whom spent time at the Maudsley) was central in taking the notion of social psychiatry even further, arguing that the genesis of mental illness could be found in society itself.[14] A student of Adolf Meyer, Lewis took up a position at the Maudsley in 1929 and, by the 1930s, was beginning to describe his patients' problems as social, rather than strictly medical, in nature.[15] The experience of WWII only furthered this conviction, cementing Lewis' beliefs that social circumstances, particularly poverty and unemployment, were central to many people's mental health problems. When the Royal Medico-Psychological Society formed a Section of Social

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[14] For work on Lewis' contributions to post-war British psychiatry, see the special supplement "European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s," eds. Katherine Angel, Edgar Jones, and Michael Neve, *Medical History* 22 (2003); David J. Harper, "Histories of Suspicion in a Time of Conspiracy: A Reflection on Aubrey Lewis's History of Paranoia," *History of the Human Sciences* 7, no. 3 (1994): 89–109; Michael Shepherd, "A Representative Psychiatrist: The Career, Contributions and Legacies of Sir Aubrey Lewis," *Psychological Medicine Monograph Supplement* 10: 1–31.

[15] Michael Shepherd, "From Social Medicine to Social Psychiatry: The Achievement of Sir Aubrey Lewis," *Psychological Medicine* 10, no. 2 (1980): 211–18; Edgar Jones, "Aubrey Lewis, Edward Mapother and the Maudsley, *Medical History* 47, no. S22 (2003): 3–38.

Psychiatry in 1946, Lewis would act as chairman. By the 1950s, Lewis, himself one of the biggest supporters of Maxwell Jones, was in the process of reconceptualising psychiatry as a discipline occupying an intermediary position between medicine and society:

> The social influences to which the patient has been exposed within his family, at school, at work, during war, in marriage, through religion and politics and recreation, are all necessary to our understanding of how he has become what he is. We concern ourselves with his relatives, endeavouring to understand and perhaps to modify their feelings and attitudes so that it will be to his advantage, and often also to theirs. We use all the socialising influences we can while the patient is under our care in hospital, and we take pains to fit him for his return to society, perhaps by altering much of the social setting to which he will return. We take full advantages of the social provisions set up by the state. In all this, the psychiatrist is practising social medicine.[16]

While the theories of the social psychiatry movement were watered down and eventually lost steam in Britain, they captured the imagination of the Yugoslav contingent of Hudolin, Petrovic, Milcinski, and subsequent practitioners who spent time training either in London or under these men. Armed with the conviction that mental illness could only be understood as the result of social relationships within the family, the workplace, and society more broadly, this cohort would return to Zagreb, Belgrade and Ljubljana, where they were each instrumental in the creation of new institutions and research that would push for a social psychiatric approach both therapeutically and preventatively.

In Belgrade, for example, the wife-husband team of Slavka Moric-Petrovic and Dusan Petrovic were driving forces behind the 1963 founding of the Institute of Mental Health, the first treatment and research facility in the Balkans to be explicitly dedicated to social psychiatry. The Institute quickly implemented many of the techniques encouraged by Jones and Bierer, including open-door day hospitals and post-treatment social clubs for patients. Moreover, they pursued a research agenda that reflected the broader conception of psychiatry as advocated by Lewis. As described by Petrovic, the Institute's mandate was to 'help the mental

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[16] Aubrey Lewis, "Social Aspects of Psychiatry," *Edinburgh Medical Journal* 58 (1951), as cited in Shepherd, "From Social Medicine to Social Psychiatry," 217.

patient to solve his problems away from the artificial divergence of the hospital' since the patient 'should be a complementary part of the social and cultural environment.'[17] To some extent, this faith in social psychiatry put Institute physicians at odds with colleagues elsewhere who still saw hospitalisation and confinement as central to treating mental illness.[18] Over the next three decades, Institute-based researchers, including Moric-Petrovic, Petrovic, Predrag Kalicanin and others, initiated research programmes that not only sought to alleviate the suffering of their individual patients, but also aimed to reveal the root causes of this suffering as well. By doing so, they hoped that psychiatry could pre-empt many cases of mental disorder.

Upon his own return from London, meanwhile, Vladimir Hudolin assumed the position of chief psychiatrist at Dr. M. Stojanovic University Hospital in Zagreb. Under his stewardship (1959–1987), researchers at the hospital developed particular strengths in the fields of alcohology and addiction, Hudolin's own specialties. Along with hospital staff, including his spouse, Visnja, Hudolin further extrapolated the social psychiatric theories that had been circulating in London during his training period with Maxwell Jones and Joshua Bierer. In time, Hudolin would become internationally renowned as a specialist on alcohol as well as one of the leading proponents of social psychiatry, eventually taking up the presidency of the World Association of Social Psychiatry (1974–1978) and acting as chief organiser of three World Congresses of Social Psychiatry (1970, 1976, 1981—all held in his native Croatia). Hudolin saw in social psychiatry the potential for revolutionising mental health care through a shift away from the psychiatric patient to the proactive 'treatment' of society itself. As he stated in his 1981 World Congress address, 'when we speak about social psychiatry it is not only some partial line of traditional psychiatry that is involved, but an entirely new course of psychiatry in general, a new perception of man and his problems in the family

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[17] Dusan Petrovic, *Institute for Mental Health Belgrade* (Belgrade: Institut za Mentalno Zdravlje, 1972), 3.

[18] Petrovic, interview with the author. Svetomir Bojanin, who also worked there, described some aspects of the Institute as outright challenges to the authorities. Their policy of keeping card indexes containing broad information related to a person's health status, personal identification, family history and other personal matters posed an obvious challenge to what Bojanin deemed the 'police state nature' of Yugoslavia. Svetomir Bojanin, interview with the author, Feb 26, 2008, Belgrade.

and in society.'[19] He saw social psychiatry's mission as to 'remove the main barriers preventing man from leading a dignified life, and from living peacefully and freely.'[20] Among these chief barriers were fear, war and intolerance—reflective of Hudolin's perception that psychiatry's role was not only to alleviate individual suffering but to catalyse wholescale social changes. In doing so, he argued, the movement faced considerable opposition from the traditional schools of organic and psychodynamic psychiatry. The dominance of these perspectives meant that '[i]nstead of submitting the family and society to a therapeutic process,' as Hudolin believed necessary, 'individuals are still being sacrificed…'[21] Thus, Hudolin advocated that psychiatry turn its gaze away from the 'so-called psychiatric patient' and instead begin to identify the social structures that were themselves the true culprits responsible for causing mental disorder.

Meanwhile, in the Slovene capital of Ljubljana, a psychiatry more concerned with society than the individual was being propagated by another practitioner who had undergone training in London—Lev Milcinksi. Milcinski, the son of a famous Slovene writer, served as a partisan in WWII and survived a stint at Dachau to become one of the most prominent psychiatrists in the country. Holding a position at the University Psychiatric Clinic in Ljubljana (1953–1982), he trained future generations of practitioners to search for the social roots behind many mental health problems. Although Milcinski's research frequently touched upon narcotic and alcohol addiction, the bulk of his work concerned suicide, a shockingly widespread issue in the otherwise peaceful republic of Slovenia. As detailed later in the chapter, Milcinski's work was strongly rooted in the notion that solving the problem of suicide involved intervention at a much broader level than the patient themselves, and he argued in favour of shifting entire cultural traditions in order to pre-emptively stem what he would eventually see as a near epidemic of self-destruction.

Thus, by the early 1960s, practitioners sympathetic to the ideas of social psychiatry were installed in many of Yugoslavia's leading clinical

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[19] Vladimir Hudolin, "Social Psychiatry Today," in *Social Psychiatry: Proceedings of the Eighth World Congress of Social Psychiatry*, ed. Vladimir Hudolin (New York: Springer, 1981), 3.

[20] Hudolin, "Social Psychiatry Today," 5.

[21] Vladimir Hudolin, "Politicization of Psychiatry and Political Psychiatry," in *Social Psychiatry: Proceedings of the Eighth World Congress of Social Psychiatry*, 34.

and training institutions. Although they never disavowed work with individual patients (indeed, Petrovic, Hudolin, and Milcinski all helped shape the contours of Yugoslav psychotherapy), these men put great stress on the need to reconceptualise the profession's mission in broader terms. While the psychiatrist might be able to alleviate suffering at the individual level, they could only prevent it by engaging at the level of society. The next section of this chapter details the attempts of Yugoslav practitioners to put these ideas into practice through short case studies of addiction, suicide and military psychiatry.

Preventative Psychiatry in Practice

In a 1957 article published in the journal *Srpski Arhiv*, Yugoslav psychiatrist Uros Jekic lamented the fact that the country's burgeoning alcohol problem might be insurmountable; the prevention of alcoholism, he argued, was a virtual impossibility in light of the discordant attitudes held by the public, government, and health services.[22] As his earlier work had suggested, the agricultural and cultural conditions of Yugoslavia (combining high quality grapes and other fruits with a history of home distilling) meant that alcohol production and consumption were near universal, exposing denizens of the country's vast rural lands to the threat of alcoholism.[23] In the words of two later practitioners, Yugoslavia was thus a country with 'maximum toleration' for alcohol consumption.[24] Psychiatrists offered up wild estimates about the scale of the problem, with Hudolin guessing that 300,000 Yugoslavs (roughly 1.5% of the entire population) might reasonably be classified as alcoholics, while later figures suggested as much as 10–15% of the adult population warranted such a diagnosis.[25] In light of such substantial numbers,

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[22] Uros Jekic, "Neki Mentalno-Higijenski Aspekti Alkoholizma," *Srpski Arhiv* 85, no. 10 (1957): 1145–53.

[23] Uros Jekic, "Alkoholizam—Problem Zdravlje," *Srpski Arhiv* 85, no. 4 (1957): 456–61.

[24] Aleksandar Despotovic and Slobodan Stojilkovic, "Socijalno i Medicinsko Znacenje Alkoholizma Psihijatrija," *Simpozij o Neurologije i Psihijatriji* (Ljubljana: 6–8 July), 1969.

[25] Vladimir Hudolin, "Prevencija Alkoholizma, Lijecenje i Rehabilitacija Alkoholicara," *Medicinski Glasnik* 15, no. 2 (1961): 76–80; I. Milakovic, "Alkoholizam—Sve Aktuelniji," *Zivot i Zdravlje* 30 (1976): 1–2.

individual treatment would be a practical impossibility, especially because rates of alcoholism appeared to be trending upward.

Prevention of alcohol addiction consequently became a priority. Many practitioners recognised that the sources of the country's high alcoholism rates were essentially social—cultural traditions of drinking, the changes wrought by modernisation and industrialisation, mechanised production—so social change became framed as an intrinsic aspect of the psychiatric solution.[26] In a 1960 paper that reflected his time spent in London (with its attention to Jones' Therapeutic Communities and Bierer's post-treatment patient social clubs), Hudolin outlined six basic tenets for tackling the alcohol problem; first and foremost was the need to galvanise widespread societal involvement in the struggle against alcoholism.[27] He called upon government agencies to give greater technical assistance to pre-existing groups dedicated to combatting drinking culture, including the Yugoslav League Against Alcoholism (founded in 1954 and comprised of trade union, youth club and sports club members) and the Red Cross. November of 1961 was subsequently declared the 'Month of the Struggle against Alcoholism,' during which time student organisations, psychiatrists and others engaged in mass public education campaigns about the dangers of drinking.[28] As part of the festivities, organisers showed films such as *Kobna Žeđ* (Fatal Thirst), distributed youth literature, and orchestrated a public display urging people to reduce alcohol consumption to avoid increases in the price of fruit (since fruit brandies enjoyed immense popularity in Yugoslavia). Uros Jekic, who had earlier declared prevention a virtual impossibility, now argued that the Month might galvanise social organisations and government institutions into making prevention a success.[29]

Another of Hudolin's basic tenets was the need to bring the family and workplace into the clinic; in this way, he aimed to subject the patient's social settings to alteration as well. Alcoholism was not, in his

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[26] For background information on alcoholism in Yugoslavia, see Mat Savelli, "Diseased, Depraved or Just Drunk? The Psychiatric Panic Over Alcoholism in Communist Yugoslavia," *Social History of Medicine* 25, no. 2 (2012): 462–80.

[27] Vladimir Hudolin, "Prevencija Alkoholizma, Lijecenje i Rehabilitacija Alkoholicara," *Lijecnicki Vjesnik* 82, no. 6 (1960): 473–85.

[28] "Program Akcije: Mesec Borbe Protiv Alkoholizma," Savez Studenata Jugoslavije (Arhiv Jugoslavije: 1961).

[29] "Zapisnik," Savez Studenata Jugoslavije (Arhiv Jugoslavije: 1961).

view, merely an issue confined to the patient but rather one of the entire social environment. Although the alcoholic himself played the starring role, family, friends and work colleagues were the supporting actors. To address this issue, Hudolin began involving the families of patients in active therapy at his clinic in the Stojanovic hospital by the early 1960s. In this system, family members underwent group therapy twice a week, and they were required to successfully pass exams on alcoholism.[30] To aid their studies, Hudolin orchestrated mandatory psycho-educative lectures on subjects such as 'How to Handle an Alcoholic' and 'Family Behaviour and Alcoholism.' He saw the wives of alcoholics, particularly, as integral to any hope for prevention. After being educated on the nature and causes of alcoholism, Hudolin believed that these women could form a special liaison with the wider community, subsequently spreading knowledge of alcoholism to family and friends.[31] This vanguard of wives could thus help to prevent future cases of alcoholism by teaching others to spot potential signs of problem drinking and to intervene pre-emptively, before an individual became a full-fledged alcoholic.

Similar psycho-educative methods were employed by Branko Gacic at Belgrade's Institute of Mental Health. Gacic, who eventually opened the Centre for Family Therapy of Alcoholism (offering courses in conjunction with the Institute for Family Therapy in London), stressed that it was not enough to simply work with the family. To truly reshape the social environment, he suggested that it was necessary that 5–10 friends and work colleagues be brought into the clinic as well.[32] These individuals would not just develop increased knowledge about the drinking disease, they would also help to create new social environments in which the pressure and incentive to drink would be diminished. Many others, such as Dragoslav Nikolic, similarly saw the workplace as the primary site of preventative intervention. Nikolic argued that 'work organizations' (self-managing bodies made up of workers and management that were charged with governing workplace rules and regulations) enjoyed

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[30] Vladimir Hudolin, "Alcoholism in Croatia," *International Journal of Social Psychiatry* 15, no. 2 (1969): 85–91.

[31] Branimir Ivan Sikic, Roger Dale Walker, and Dennis R. Peterson, "An Evaluation of a Program for the Treatment of Alcoholism in Croatia," *International Journal of Social Psychiatry* 18, no. 3 (1972): 171–82.

[32] Branko Gacic, "Petnaest Godina Porodicne Terapije Alkoholizma—Rezultati i Implikacije," *Psihijatrija Danas* 21, no. 1 (1989): 85–92.

the best position to prevent alcoholism.[33] For example, the legal power of these work organisations could be used to ban the sale of alcohol within worksite cafeterias or to forbid employees in particular positions from drinking on the job, a rather common occurrence among Yugoslav labourers.[34] Moreover, they could also extend the psycho-education envisioned by Hudolin by offering it en masse to employees directly at work.

All of these interventions—whether targeting family, the workplace, or the public at large—set about preventing alcoholism through an alteration of the individual's social environment. While it might be tempting to draw an analogy to Yugoslav society more broadly—itself in the midst of Socialist revolution—the logic that one could change society to prevent alcoholism relied primarily upon Hudolin's links to the global social psychiatry movement, rather than any ideological fountainhead. In short, the Yugoslav focus on prevention rested upon the simple principle that, while genetics and individual psychological dispositions were potentially significant, nothing was more central to mental well-being than the social environment.

The need to utilise a social approach was similarly underscored by those working on the issue of suicide. Undoubtedly, the most significant voice in this regard belonged to Lev Milcinski, the creator of the Yugoslav Association for Suicide Prevention and its honorary life president. Working in the Slovene capital of Ljubljana, Milcinski had good reason to focus on the topic of suicide; although Yugoslavia's suicide rate was in line with the European average, Slovenia's was among the highest in the world throughout the Communist era, being described by several commentators as the 'national problem.'[35] Suicide rates continued to rise throughout much of the post-WWII period and researchers across Slovenia published dozens of papers on the subject. While some dedicated themselves to trying to work out what psychological problems might underpin suicide attempts, Milcinski instead argued that it

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[33] Dragoslav Nikolic, "Primary Health Care and Alcoholism in Yugoslavia," *Socijalna Psihijatrija* 15, no. 3 (1987): 273–80.

[34] Joko Poleksic, "Alkoholizam U Industriji," *Engrami* 7, no. 4 (1985): 59–60.

[35] Lev Milcinski, "Reflections on Specific Features of Suicide in Yugoslavia," *Socijalna Psihijatrija* 3, no. 4 (1975): 289–98; C. Pahjlina, D. Boden, J. Barboric, V. Decko, M. Vrabic, and C. Kavcic, "Samoubojstva Na Podrucju Celjske Regije," *Engrami* 3, no. 3 (1981): 45–54.

was important to view self-destruction as a social phenomenon, rather than simply the result of individual mental defect. Any number of social factors—economic status, migration, culture—were all potential contributors to an individual's decision to end their life. In making that appeal, he drew upon the wider field of suicidology, stretching back from Durkheim to contemporaneous theorists like Erwin Stengel and Erwin Ringel, both of who, like Milcinski, were active members of the International Association for the Prevention of Suicide.

By defining suicide as a social problem, rather than an individual one, it became clear that psychiatrists and other physicians alone would not be able to tackle the suicide problem. Prevention, then, could only come about through the involvement of a broad coalition of social and medical forces. The first attempt to really bring together these disparate actors culminated in the First Yugoslav Symposium on the Prevention of Suicide in Zagreb in 1972. Led by Milcinski, the meeting saw psychiatrists team up with individuals from outside the medical community, including sociologists, lawyers, and the public security services, among others. The expectation and hope, at least according to Milcinski, was that the combined experiences and knowledge of those attending could create new and more effective pathways towards prevention.[36] The theme of socio-medical preventative efforts reverberated through the second major meeting on suicide prevention as well, held in 1975. During the conference discussion, the physicians in attendance rejected any medical monopoly on suicide, inviting greater participation on the part of other public bodies. Particularly, a number of participants advocated closer cooperation with the department of internal affairs, highlighting the potential of the police to aid medical staff.[37] Like Hudolin, who helped create a republic-wide register of alcoholics in Croatia, Milcinski convinced the Slovene authorities to establish a register of all suicides and suicide attempts in the mid-1970s.[38] The epidemiological

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[36] Lev Milcinski, "Uvod," *Zbornik Radova 1. Jugoslavenskog Simpozija o Prevenciji Samoubojstva* (Zagreb, 1973).

[37] Anica Kos-Mikus, "Diskusija Treceg Dana Simpozijuma: Grupa A," *Zbornik Radova 2. Jugoslavenskog Simpozija o Prevenciji Suicida* (Galenika: Belgrade, 1975).

[38] Suicidologists debated the creation of a national register of suicides to combat this problem, although such a database was only realised in Slovenia. See the general discussion from the Second Yugoslavia Symposium on the Prevention of Suicide, "Opsta Diskusija," *Zbornik Radova 2.*

charting of suicides, he hoped, would shed light on social roots of the phenomenon, thus pointing the way to the best methods of prevention.

Because of their shared devotion to social psychiatry, it is unsurprising that a number of suicidologists also raised the possibility of implementing a variation of the social clubs model originally theorised by Joshua Bierer, especially since Hudolin had done this to great effect with alcoholics. In essence, these clubs provided individuals at risk for mental health problems with alternative social environments, where they could build less pathological relationships and engage in healthier behaviours. The suicidologists' interest in the clubs-based approach also reflected their belief in substantial overlap between those that committed suicide and those that were alcoholic. Preventing alcoholism would, they concurred, have significant knock-on effects on the suicide rate. Milcinski, for instance, described the 'intense anti-alcohol struggle' being waged in Slovenia as the best hope for lowering the suicide rate.[39] Fellow Slovene Janez Rugelj, meanwhile, suggested that an alcoholic left to his own devices would almost inevitably result in self-inflicted death, since suicide was essentially the only possible solution to the 'inescapable degradation' of the drinker's mental state. Rugelj put forth a strong case for suicidologists to adopt the clubs-based model, since the alcohol-related clubs in Slovenia had not once lost a member to suicide.[40]

The push for implementing the clubs-based approach could be understood as part of a further effort to spread the responsibility for suicide prevention beyond the realm of the medical practitioner. Reared on the ideas of social psychiatry, these practitioners saw effective suicide prevention as something that could only be brought about through collaboration with a host of non-medical actors. Thus, practitioners actively rejected attempts to define the issue of suicide solely along mental health lines, eschewing broader trends towards medicalisation. In a sense, this process echoed a broader demedicalisation of psychiatry itself, whereby many Yugoslav practitioners saw their work as only partially occurring within the medical sphere. While of course physicians, they also conceived of themselves as engaging with the tools and epistemologies of

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[39] Lev Milcinski, "Pitanja Istrazivanja I Prevencije Samoubistva U Sloveniji," *Zbornik Radova 1*.

[40] Janez Rugelj, "Samoubistva Alkoholicara Koji Su Bili Hospitalno Tretirani Metodom Kompleksnog Socijalno-Psihijatrijskog Lijecenja," *Zbornik Radova 2*. See also his comments in the general discussion of that conference.

anthropology, sociology and other disciplines that cultivated a deeper understanding of the social environment.

Yet the emphasis on prevention was not restricted solely to those idealistic individuals that had cultivated ties with the broader social psychiatry movement. Practitioners working within military medicine, a subfield of immense importance (given that Yugoslavia was perhaps the most militarised society in Europe), also saw the utility of extending psychiatry's reach beyond treatment and into the realm of prevention. Fearing potential attack from both Western powers and the Soviet bloc, the Yugoslav People's Army (JNA) drew up plans to contain the possibility of future outbreaks of mass hysteria and war neurosis, especially in the event of enemy strikes. Lieutenant General Milojica Pantelic, speaking at a conference entitled 'The Symposium on Psychiatry in Extraordinary Situations,' laid out the primary concerns of the JNA in this respect.[41] Firstly, he explained how the Yugoslav military's strategy for dealing with invasion relied primarily upon the total mobilisation of the Yugoslav people. Every segment of society would be instantly turned into a sort of guerrilla force, reflecting the partisans' successful tactics during WWII.[42] As a consequence, having a national plan to prevent psycho-trauma was of fundamental importance. In particular, he underscored military concern about the psychological effect of a surprise attack on the civilian population. He urged mass psychological preparation for the possibility of war as an important step, and reasoned that in the event of conflict, psychiatrists should mobilise themselves and concentrate on those regions under attack from tanks, nuclear rockets and other aviation threats. Moreover, he noted, the population should be mentally prepared to comprehend the back and forth nature of war. Should a given city or republic fall, they must not be traumatised. Only through these preventative steps, he argued, could Yugoslavia win a future national war of defence.

Tomislav Kronja and Slobodan Stojilkovic, two prominent Belgrade practitioners, noted that future wars would involve extraordinary tests of

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[41] Milojica Pantelic, "Savremena Koncepcija Opstenarodnog Odbranbenog Rata," *Prvi Jugoslovenski Simpozijum o Psihotraumatizovanim u Vanrednim Situacijama* (held in Basko Polje, 4–6 May, 1970).

[42] For an excellent discussion of how the military envisioned these tactics, see Tomislav Dulic and Roland Kostic, "Yugoslavs in Arms: Guerilla Tradition, Total Defence and the Ethnic Security Dilemma," *Europe-Asia Studies* 62, no. 7 (2010): 1051–72.

civilian resolve.[43] Yugoslavia, never imagined as the potential aggressor, might face any manner of enemy attack. In these instances, citizens and soldiers would need steely morale, emotional stability and a high degree of self-certainty. They blamed the nuclear powers for waging a war of psychological intimidation against the 'peace loving peoples of the world' (i.e. Yugoslavs and the rest of the Non-Aligned Movement) by using the threat of the bomb to misinform the public and spread panic among the masses. The peaceful nature of Yugoslavia, they argued, might actually make the country more prone to psycho-trauma in the event of attack. The essence of their programme was to improve people's tolerance of psychological stress. They singled out fear as the most debilitating threat in terms of traumatising the population. To counter this danger, they devised several goals, including better overall mental hygiene and greater physical conditioning because 'a healthy body creates a healthy mind.' Moreover, they suggested that citizens would better handle the stresses of war through more familiarity with modern machinery and industry and a stronger overall knowledge of the tools of war (quite specifically, this included all types of conventional weapons, plus education on the atom bomb and biochemical weapons). If citizens could be given this knowledge, they argued, they would no longer suffer from fear of the unknown. They argued that the government and military could encourage these qualities by organising symposiums and courses on these topics, conducting exercises in preparation for the war, training health cadres for this particular type of activity and boosting psychiatric research in this domain. As a last component of their plan, they also encouraged the formation of psychiatric teams (comprised of a psychiatrist, psychologist, and social worker) to work preventatively with those likely to suffer trauma in the event of war breaking out.

Naturally, not all psychiatrists approached the problem from the same perspective. Janko Kostnapfel, during a presentation to a non-military audience at the Third Congress of Yugoslav Doctors in 1971, put forth the notion that war itself was 'the worst mental illness of mankind.'[44] Conflict, rather than something to be celebrated, was largely

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[43] Tomislav Kronja and Slobodan Stojilkovic, "Preventivne Mere U Okviru Zdravstvene Sluzbe Jugoslavije U Pripremi Ljudstva Za Opstenarodni Odbrambeni Rat," *Prvi Jugoslovenski Simpozijum.*

[44] Janko Kostnapfel, "Rat I Mir Sa Stanovista Psihijatrije," *III Kongres Lekara Jugoslavije* (held in Bled, 5–8 October, 1971).

the responsibility of individuals with excessively egotistical personality structures. Such people thrived during conflict, he warned, noting that they lost their day-to-day anxieties and actually enjoyed a simpler and clearer life. Thus, rather than fortifying the population against the threat of wartime psycho-trauma, Kostnapfel saw psychiatry's role as working to improve society's mental health as a whole. In doing so, the profession could actively work against such personality types and help to prevent the outbreak of war. In a Yugoslavia that had too often known the otherwise unthinkable horrors of war, Kostnapfel's vision of preventative psychiatry could not have had a more noble aim.

Conclusion

The preventative psychiatry envisioned by Yugoslav theorists was, by and large, one of self-belief and optimism. War fears aside, these theorists saw in their profession not only a possibility, but also a responsibility, to fundamentally alter the nature of Yugoslavia and human society more generally. The assertions of Kostnapfel, that psychiatry might prevent future outbreaks of war, were not out of place within the context of Yugoslav psychiatry. Hudolin had similarly lofty ambitions for his colleagues across the world, with whom he pleaded to abandon the classical thinking of their discipline:

> I have already expressed the opinion that the majority of socio-psychiatric problems do not originate in classic etiological factors which traditional psychiatry attempts to manipulate, but are instead stimulated by fear, aggression and intolerance, which seem to have assumed planetary proportions as never before in human history… If the factors mentioned previously are the cause of most mental disorders, it would be normal to expect that contemporary psychiatry should devote due care to them.[45]

Ultimately, however, the hope that psychiatrists might act as 'social change agents,' as Maxwell Jones had once described, would be seemingly extinguished. After President Tito's death in 1980, Yugoslavia began to unravel, first economically, but then socially and militarily. Market shortages, inflation and unemployment combined with a powerful amplification of previously muted nationalist discourses to produce a

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[45] Vladimir Hudolin, "Politicization of Psychiatry and Political Psychiatry," 31–32.

climate of uncertainty. Citizens across the country experienced bewilderment and sensations of losing any sort of agency in their own lives.[46]

Many of these sentiments seemed to have spread to psychiatry as well. Vladimir Paranosic and Predrag Kalicanin, who had been a central figure within the social-psychiatrically oriented Institute of Mental Health, published a 1989 article that reflected the loss of optimism about psychiatry's potential to prevent mental suffering. The deteriorating social situation, not only in Yugoslavia but across the rest of the world, seemed to them an almost insurmountable barrier. Psychiatry, in their view, could not truly expect to solve the roots of poor mental health, which could be found in such processes as marginalisation, 'the ghettoisation of the elderly' and limitations on people's ability to choose their own fate. Seeing a world in disarray, they suggested that 'to suggest choosing healthy lifestyles to young people who have been waiting years for employment borders on the hypocritical (regardless of whether they are Yugoslav, Italian, or American). To speak about improving the mental health of people isolated in torturous totalitarian regimes is, at the very least, cynical.' These statements, they continued, were equally valid for both underdeveloped societies and wealthy nations; only political change, rather than psychiatric intervention, could alter this situation. While earlier theorists had seen the possibility for psychiatry to be at the vanguard of these social changes, by this point it simply appeared beyond the profession's scope. A few short years later, conflict would consume the former Yugoslavia, and its practitioners would largely return to the 'traditional approach' so detested by figures like Hudolin. Rather than attempting to prevent mental illness (or even war), they found themselves in hospitals and offices, across Yugoslavia and as migrants abroad, largely attempting to treat people's war trauma.

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[46] Dusan Kecmanovic, *Ethnic Times: Exploring Ethnonationalism in the Former Yugoslavia* (Westport: Praeger, 2002).

CHAPTER 7

The History of Suicide Prevention in Finland, 1860s–2010s

Mikko Myllykangas

Introduction

'How to prevent suicides' is a question with constantly changing answers. Whether suicide has been regarded as nature's purging process or a symptom of a chemical imbalance in the brain, the approach to preventing suicides has for the past 200 years reflected the contemporary scientific understanding and theories about the causes of suicides.[1] In this chapter, I examine the relationship between the scientific understanding of suicide and the prevailing practices of suicide prevention and how the latter have been formulated in accordance with the former. My focus is on the history of suicide prevention in Finland between the nineteenth century and the present decade.

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[1] See e.g. Ian Marsh, *Suicide: Foucault, History and Truth* (Cambridge: Cambridge University Press, 2010); Robert A. Houston, "The Medicalization of Suicide in Scotland and England," in *Histories of Suicide*, eds. John Weaver and David Wright (Toronto: University of Toronto Press, 2009), 91–118.

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Even though the concept of 'suicide prevention' only emerges in a cohesive form in the 1950s, it is worthwhile to look further back in time to see the changes in the complex interplay between a real-world issue, scientific theory construction, and social and cultural environment, in which it all has unfolded. In this regard, Finland presents an interesting case to study. In the nineteenth century, the country was peripheral in an international comparison of suicide statistics. During the twentieth century, however, Finland surpassed Western European nations, and by the last decades of the century, Finland was comparable with countries such as Japan and Hungary, which had some of the highest suicide frequencies in the world. By the third millennium, things have turned around once more, and the Finnish suicide frequency is at its lowest since the 1920s.

The Becoming of Suicide Prevention into a Matter of Scientific Discussion

Historically, suicide prevention has always reflected the prevailing scientific understanding of suicide. In fact, as we look at the early nineteenth-century scientific discourse of suicide, it is hard to find any treaties on suicide without any reference to the question of how to prevent them. In the late 1830s, Jean-Étienne Dominique Esquirol (1772–1840) dedicated several pages in his seminal work *Des maladies mentales* to the subject of suicide prevention. Traditionally suicide had been punished by the laws. But, according to Esquirol, suicide was 'almost always the effect of disease' and thus it was not justified to punish those who committed suicides or their relatives.[2] Instead, those who suffered from suicidal delusions should be referred to treatment.[3] As Ian Marsh has noted, not only did Esquirol write about psychiatric theory and the treatment of the mentally ill, but he also worked to establish psychiatry among the medical disciplines. A demonstration of the connection between suicide and mental illness would solidify the status of psychiatry in the public debate about how to best counter the increasing numbers of suicides in the industrialising societies.[4] In this process, suicide came

[2] Jean-Étienne Dominique Esquirol, *Mental Maladies*, engl. trans. E.K. Hunt (Philadelphia: Lea and Blanchard, 1845), 312–13.

[3] Esquirol, *Mental Maladies*, 307.

[4] Marsh, *Suicide*, 100.

to be viewed as a form of madness of its own.[5] According to Marsh, 'the constituting of medical formulations of suicide as empirical and scientific truths acted to strengthen the position of alienists in relation to competing claims from the law and the Church'.[6]

It was only two decades after the publication of Esquirol's famous work that his ideas on the connection between madness and suicide were cited in the first two scientific studies on suicide in Finland. In 1861, in a brief forensic study of suicide, Finnish jurist Robert Lagus (1827–1864) argued for decriminalisation. Based on statistical data, Lagus stated that since most suicides were committed in a bodily or spiritual state of distress, it was not justified to punish suicidal individuals.[7]

Three years later, in 1864, medical doctor and future chief physician of Finland's first modern asylum, Thiodolf Saelan (1834–1921) published his doctoral thesis, a statistical and medico-legal study of suicide in Finland, *Om Sjelfmordet I Finland I statistiskt och rättmedicinskt afseende*. However, Saelan, as well as several of Esquirol's fellow French psychiatrists, was doubtful about the universal connection between madness and suicide. Referring to Pierre-Égiste Lisle and Jean-Pierre Falret, Saelan stated that he found Esquirol's statement unlikely to accurately reflect the reality of suicides. Many historical cases (for example suicides by Cato and Brutus), as well as suicides by rational persons who Saelan had personally known, had convinced him that not every suicidal individual should be regarded as a madman.[8] From this it followed that suicidal individuals should be categorised in two separate groups. Mentally ill individuals were to be hospitalised and prevented from committing suicide while institutionalised.[9] Saelan used separate categories for 'madness', 'religious delusions', 'alcohol misuse' and 'melancholia', all of which would be regarded as mental health disorders today. But in many cases, much in line with the notions of modern social psychiatric understanding, Saelan stated that the immediate cause of suicide could only

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[5] John Weaver, *A Sadly Troubled History: The Meanings of Suicide in the Modern Age* (Montreal: McGill-Queen's University Press, 2009), 35.

[6] Ibid., 108.

[7] Robert Lagus, *Juridiskt Album* (Helsingfors: J. Simelii, 1861), 90.

[8] Theodolf Saelan, *Om Sjelfmordet I Finland I statistiskt och rättmedicinskt afseende* (Helsingfors: J. C. Frenckell & Son, 1864), 4–5, 47–52.

[9] Ibid., 63.

be regarded as a catalyst and the fundamental cause of suicide was something to be found in the social environment and the prevailing culture.

By the second half of the nineteenth century, it was rather common to point at the relatively rapidly changing society as the ultimate reason why suicides were becoming more common in the industrialising societies. The French psychiatrist Alexandre Brierre de Boisemont (1797–1881), after analysing suicide statistics of the urban centres and countryside of France, argued that there was something pathological in the urban lifestyle, and called for moral education to combat the increasing urban suicide numbers.[10] Highly agrarian Finland of the mid-nineteenth century was in no way comparable to the industrial societies of France or England.[11] However, the fact that only a very small proportion of the population of Finland lived in the country's few and rather small cities did not stop Saelan from recommending such measures to prevent suicide that were familiar from the transnational scientific discourse of suicide.

As urbanisation and industrialisation had not yet started in Finland by the middle of the century, Saelan's statement tells us more about how familiar he was with the central themes of the international suicide research. Urban lifestyle was probably the single most pointed out social condition linked with self-destruction by suicide researchers on both sides of the Atlantic.[12] Suspicion towards life in cities was quite widespread among psychiatrists, and to understand the modern suicide phenomenon, one only needed to look at the fall of Rome, Saelan wrote, to see how the urban way of life turned freedom to slavery and civilisation into degeneration.[13] Marsh has argued that the nineteenth-century psychiatric discourse of suicide was a mixture of medical, scientific and moral statements. Medical professionals regarded suicide, even though decriminalised or in the process of decriminalisation, still with condemnation and repulsiveness.[14] Saelan was not any different, and he stated

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[10] Weaver, *Sadly Troubled*, 39–40.

[11] In 1870s, only 4% of the population earned their livelihood in industrial occupations. Viljo Rasila, *Torpparikysymyksen ratkaisuvaihe* (Helsinki: Suomen Historiallinen Seura, 1970), 18.

[12] Howard Kushner, *Self-Destruction in the Promised Land* (New Brunswick: Rutgers University Press, 1989), 46–48.

[13] Saelan, *Om Sjelfmordet*, 64–65.

[14] Marsh, *Suicide*, 136–38.

how suicides were ‘usually committed for minor and despicable motives by people who do not deserve any lengthy in-depth treatise written about them’.[15] Accordingly, the best ways to prevent suicides among the common people, based on the suicide statistics, was to go against drunkenness and to organise poor relief.[16] In the end, boozing and destitution were hardly included among the noble and noteworthy motives of suicide.

To put all of this into perspective, around the middle of the nineteenth century, suicide was a comparatively small issue in Finland. The annual Finnish suicide rate hovered at around three suicides per 100,000 inhabitants; in many European countries, similar figures were three to five times higher. For example, in the 1860s, in Norway and in Sweden the figure was 8.5, and in Denmark a whopping 27 suicides were committed per 100,000 inhabitants.[17] Finnish suicide rates reached an internationally comparable level during the first decades of the twentieth century (c. 10/100,000), still remaining low in comparison to other Nordic countries. For example, during the same period, Swedish and Danish suicide rates were 15.1 and 20.9, respectively.[18]

The way that suicide was situated within the social and cultural framework did slowly change, however. We can assume that Lagus and Saelan, by including suicide into scientific discourse, contributed to the decriminalisation of suicide. As historian Katariina Parhi has pointed out, Saelan’s position on diminished responsibility was an elemental part of discussion aimed at reforming the penal code in the 1870s and 1880s.[19] Even though we do not have direct evidence of Saelan’s participation in the process of outlining the new penal code, it is safe to assume that his take on suicide was regarded as expert opinion, since he was the highest psychiatry authority in Finland. As suicide was removed from the Finnish

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[15] Saelan, *Om Sjelfmordet*, 66.

[16] Ibid., 67.

[17] Fredrik Westerlund, “Själfmorden i Finland 1861–1895,” *Bidrag till kännedom af Finlands natur och folk 58* (Helsingfors: Finska Vetenskaps-Societeten, 1900), 138, 140, 142.

[18] Toivo Nygård, *Itsemurha suomalaisessa yhteiskunnassa* (Jyväskylä: Jyväskylän yliopisto, 1994), 31–34; Veli Verkko, *Homicides and Suicide in Finland and Their Dependence on National Character* (København: G. E. C. Gads Forlag, 1951), 122–23.

[19] Katariina Parhi, “Young Man M: Political Violence, Moral Insanity, and Criminal Law in Finnish Psychiatry in the 1870s and 1880s,” *Scandinavian Journal of History* 43, no. 1 (2018), https://doi.org/10.1080/03468755.2018.1430582.

penal code in 1889,[20] the legal reform concerning suicide in Finland fell in the middle ground between the early reformers of the beginning of the nineteenth century, such as France, and the latecomers, such as the Russian Empire (suicide was decriminalised after the revolution in 1917) and England (1961).[21] However, it is worth considering that legislative reforms targeting suicide worked hand in hand with emerging scientific forms of public discussion of this formerly legally, morally, philosophically and theologically treated complex social issue. As we know, since the early nineteenth century, it has been the psychiatrists who were more interested in studying and explaining the suicide phenomenon. And, as we will see, during the twentieth and the twenty-first century, the main body of knowledge on how to prevent suicides has been produced in and around the discourse of psychiatry.

Suicide as a Social and an Individual Pathology

The Finnish suicide research and discussion on prevention was anything but intense during the nineteenth century, and the next contribution was published almost four decades after Saelan's preliminary work. Completed in 1897 and published in 1900, a comprehensive statistical analysis of Finnish suicide, 'Självmorden i Finland 1861–1895' ('Suicide in Finland 1861–1895') by the physician Fredrik Wilhelm Westerlund (1844–1921) continued from where Saelan had left off. Much like his predecessor, Westerlund closely knit his work together with the latest international trends of ideas in suicide research.

During the three decades following the publication of Darwin's *On the Origin of Species*, the theory of evolution was applied in numerous statistical studies of suicide. One of the most famous and influential was the Italian psychiatrist Enrico Morselli's (1852–1929) *Il Suicidio*, published in 1879, and quickly translated in English and German. It was the German translation of Morselli's seminal work that formed the theoretical backbone of Westerlund's analysis of the Finnish suicides.

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[20] The 1889 penal code was ratified only in 1894, after five years of reviewing by the Russian officials. Nygård, *Itsemurha*, 125; Anu Salmela, "Kuolemantekoja: Naisten itsemurhat 1800-luvun jälkipuolen tuomioistuinprosessissa" (Ph.D. diss., University of Turku, 2017), 19.

[21] Susan Morrissey, *Suicide and the Body Politic in Imperial Russia* (Cambridge: Cambridge University Press, 2006), 77–78.

Morselli argued that the increase in suicide rates in many European nations was due to the modernisation process, including industrialisation and urbanisation, which in turn caused the 'struggle for existence' to be fought intellectually. The psychological strain caused by intellectual competition shattered modern man's nerves and caused all kinds of psychological abnormalities that could result in suicide. Hence, Morselli regarded suicide as a disease of modernity, a price to be paid by the society in order to gain progress.[22] Furthermore, statistical regularities had proven, at least in Morselli's eyes, that suicide could not be regarded as a voluntary action, but it was determined by social and psychological forces outside of an individual's control.[23]

As the Western European nations struggled with the side-products of modernisation, Westerlund noted that suicide in Finland sprung up from very different kind of sources. The famine years of 1866–1868 had generated a spike in the suicide statistics, and Westerlund argued that social and economic improvements would be the right way to approach the prevention of suicide in Finland. According to Westerlund, the way that the society was developing could be affected by voluntary human actions and in no way was the suicide phenomenon destined to become worse over time.[24]

Westerlund's standpoint was parallel to that of Russian suicide researchers in the 1880s. They saw a possibility to prevent suicides by addressing the issue through social actions. They suggested social and economic reforms to level the differences between social classes. Even though a moral education of the lower classes was increasingly promoted by the end of the century due to the rising fears of degeneration, as historian Susan Morrissey has pointed out, the Russian psychiatrists also considered suicide to be a social illness that could be cured by improving the health of society.[25] For Westerlund, this also included public education against 'disastrous' habits, such as alcohol consumption. Misuse of alcohol was listed as the second highest cause of suicide, and according to Westerlund, there were many more cases where alcohol usage could

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[22] Dan Lederer, "Sociology's 'One Law': Moral Statistics, Modernity, Religion, and German Nationalism in the Suicide Studies of Adolf Wagner and Alexander von Oettingen," *Journal of Social History* 46, no. 3 (2013): 690–93.

[23] Enrico Morselli, *Suicide* (New York: D. Appleton, 1882), 16.

[24] Westerlund, "Självmorden," 273–74.

[25] Morrissey, *Suicide*, 187–88, 197–98, 202.

be regarded as having played a part in the suicide process. For example, he argued that in many cases mental illness, which had been stated as the cause of suicide, was in fact caused by alcohol.[26] In this respect, Westerlund's study was framed by yet another emerging theme of the late-nineteenth-century medicine and psychiatry: the rise of the temperance movement in Finland. Again, the fear of degeneration fuelled the increasing labelling of alcohol use as a threat to national health.[27]

Even though there are no direct references between Westerlund's work and his Russian counterparts, we can assume that the somewhat similar economic and material conditions of Finnish and Russian societies presented a certain kind of social framework, in which the Finnish and Russian suicide researchers applied the theories of suicide that had originated in countries further down the road of modernisation. The Grand Duchy of Finland, as a part of the Russian Empire until 1917, was a latercomer in industrialisation, and therefore, as Westerlund himself had acknowledged, the country was spared from many of the ill effects of modernisation.[28]

Aside from references to the vaguely defined theory of degeneration, the discourse of suicide and suicide prevention did not go through any significant theoretical changes during the second half of the nineteenth century. Moral statistics formed the backbone of the studies on suicide, while the explanations and possible prevention methods of suicide were based on calculations from the statistical data. By the first decades of the twentieth century, Finnish medicine in general was strongly influenced by Germany,[29] and the close affiliation with German psychiatry meant that the Finnish discourse of suicide would be reformed under the influence of biologically oriented psychiatric theories.

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[26] Westerlund, "Självmorden," 266.

[27] Matti Peltonen, *Kerta kiellon päälle. Suomalainen kieltolakimentaliteetti vuoden 1733 juopumusasetuksesta kieltolain kumoamiseen 1932* (Helsinki: Tammi, 1997), 75; Markku Mattila "Suomalaisten lääkärien suhtautuminen rotuhygieniaan ennen ensimmäistä maailmansotaa," in *Rasismi tieteessä ja politiikassa*, ed. Jouko Jokisalo (Helsinki: Edita, 1996), 75.

[28] Westerlund, "Självmorden," 274.

[29] Mikko Myllykangas and Katariina Parhi, "Unjustified Emotions: Child Suicide in the Finnish Psychiatry from the 1930s Until the 1970s," *The Journal of the History of Childhood and Youth* 9, no. 4 (2016): 489–508.

As psychiatry in Germany in the nineteenth century had moved towards a distinctly biologically oriented paradigm,[30] psychiatrist Ernst Kretschmer (1888–1964) presented his theory of constitutional types at the beginning of 1920s. Kretschmer's typology of different body-types and corresponding mental characteristics quickly gained a following among Finnish psychiatrists, and one can find references to Kretschmer's theory in the Finnish psychiatric literature until the 1960s.[31] In 1931, for Oiva Elo (1896–1942), a physician specialised in mental disorders and medical jurisprudence, Kretschmer's typology presented an opportunity to create predictions concerning possible future suicidal behaviour. As a matter of fact, Elo was the first among the Finnish suicide researchers to point towards the crucial difference between attempted suicide and completed suicide, and to ground a systematic psycho-physiological analysis on Kretschmer's typology of physical and metal constitution, in order to provide an insight into the suicide phenomenon. As Elo was especially interested in suicides by mentally 'normal' individuals, the theory of constitutional types could explain why certain people killed themselves and others did not whilst under seemingly identical circumstances.[32] Elo's approach, even though downplayed by psycho-dynamically oriented psychiatrists of the 1960s,[33] can be regarded as revolutionary, as, unlike his predecessors, he studied suicides in order to understand what exactly made some people commit suicide, and how this 'suicidal type' could be distinguished from the rest of the population. Even though vastly different in some respects, Elo's approach, in which possible suicides could be anticipated by constitutional characteristics, with its strong reliance on a biological understanding of psychological features is not that far apart from present-day efforts

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[30] John Gach, "Biological Psychiatry in the Nineteenth and Twentieth Centuries," in *History of Psychiatry and Medical Psychology*, eds. Edwin Wallace IV and John Gach (New York: Springer, 2008), 382–85; Andrew Scull, *Madness in Civilization* (Princeton: Princeton University Press, 2015), 262–63.

[31] Mikko Myllykangas, "Rappeutuminen, tiedostamaton vai yhteiskunta? Lääketieteellinen itsemurhatutkimus Suomessa vuoteen 1986" (Ph.D. diss., University of Oulu, 2014), 127, 149.

[32] Oiva Elo, "Über Selbstmorde und Selbstmörder in Finnland," *Deutsche Zeitshrift für die gesamte gerichtliche Medizin* 17, no. 1 (1931): 399–441.

[33] See e.g. Kalle Achté, "On the History of Suicidological Research in Finland," *Psychiatria Fennica* (1975): 257–65.

to discover a genetically influenced ‘suicide trait’ making a person more likely to commit suicide under stressful circumstances.[34]

While Elo had pointed at special biological characteristics of those who commit suicide as a possible method to identify those in danger of committing suicide, the next Finnish author who tried to solve the mystery of suicide identified the (supposed) nationwide characteristics of the Finnish people as the key components in suicide. During the late 1940s, internationally renowned criminologist and professor of sociology Veli Verkko (1893–1955) combined early twentieth-century ethnographic theories with Kretschmer’s constitutional typology in his analysis of Finnish statistics of suicide and violent crimes, and came to the conclusion that the Finnish ‘national characteristics’ mixed poorly with alcohol consumption. Athletic constitution, typical for Finns according to Verkko, had been associated with a quick drinking style and belligerence while intoxicated, and therefore proneness to violent crimes and suicide.[35] Even though Verkko’s theory appears as an oversimplification, it was rather typical for the Finnish psychiatrists in the 1940s to associate alcohol consumption, assumed national psychological and physical characteristics and undesired behaviour in the spirit of the temperance movement.[36] Cutting back on alcohol consumption might have had some positive effects on national health and maybe on suicide figures also. However, the full complexities of the suicide phenomenon began to be revealed only after a dedicated sub-discipline of psychiatry, suicidology, began to emerge in the late 1950s.

LIFTING THE SHROUD OFF THE TABOO: PROFESSIONALISATION OF SUICIDE RESEARCH AND PREVENTION

If the pre-Second World War conceptions of suicide and suicide prevention had arrived in Finland from Germany, the post-war discourse of suicide prevention was inspired by the emergence of suicidology in the United States. Generally speaking, the psychiatric suicide research and the discourse of suicide prevention as we know it today began to take form

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[34] See “Conclusion.”

[35] Verkko, *Homicides*, 140–44.

[36] See e.g. Hannes Heikinheimo, *Sielunterveys ja sen hoito* (Turku: Kustannusosakeyhtiö Aura, 1946), 86–87.

internationally during the later part of the twentieth century. In 1960, Austrian psychiatrist Erwin Ringel (1921–1994) together with American psychologist Norman Farberow (1918–2015) founded the International Association for Suicide Prevention. In the following year, Farberow and his colleague Edwin Shneidmann (1918–2009) published *Cry for Help*, a collection of social psychiatric and psychoanalytical studies of suicide. Furthermore, they presented guidelines for establishing community measures for suicide prevention and how to dispel some of the widespread myths concerning suicide. It was common for people to think, for example, that 'people who talk about suicide won't commit suicide' and 'suicide happens without warning'.[37] Many of these views are still repeated in suicide prevention guidelines today.[38] Theory building to explain the suicide phenomenon was also backed up for the first time by developing measures at grassroots level to help people in suicidal crisis through the establishment of the Suicide Prevention Center in Los Angeles in 1958.[39]

Public and professional ignorance and misconceptions about suicide called for better education about the facts of the suicide phenomenon. However, it was only a part of why the prevention of suicide was a difficult task to accomplish. In 2001, Norman Farberow looked back to the early days of suicide prevention and noted how the taboo surrounding suicide had been a significant obstacle to suicide prevention.[40] In 1961, Farberow stated that 'the predominant attitude of civilized society toward suicide' was one of condemnation.[41] In 1963, Edwin Shneidman wrote how suicide being a taboo subject was hindering both the study of suicides and their prevention, as people were unwilling to discuss the subject.[42] It looked like one hundred years of scientific research

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[37] Edwin Shneidman, Norman Farberow, and Robert Litman, "The Suicide Prevention Center," in *Cry for Help*, eds. Norman Farberow and Ewdin Shneidman (New York: McGraw-Hill Book, 1961), 13.

[38] See e.g., World Health Organization, *Preventing Suicide: A Resource for Primary Health Care Workers* (2000), 12.

[39] Shneidman, Farberow, and Litman, "Suicide Prevention," 6.

[40] Norman Farberow, foreword to *Suicide: An Unnecessary Death*, ed. Danuta Wasserman (Oxford: Oxford University Press, 2016), xxx.

[41] Norman Farberow and Edwin Shneidman, "Introduction," in *Cry for Help*, eds. Farberow and Shneidman, 3.

[42] Edwin Shneidman, "Suicide," in *Taboo Topics*, ed. Norman Farberow (New York: Atherton Press, 1963), 41–42. The text was also translated into Finnish and published in Finland in 1967. Edwin Shneidman, "Itsemurha on Tabu," *Medisiinari*, no. 3 (1967): 47–50.

of suicide had done nothing to age old attitudes towards self-killing. However, it was no wonder that suicide was still a taboo by the second half of the twentieth century. During the nineteenth century, the first few generations of suicide researchers had indeed dragged self-murder from the shades of moral condemnation into the light of science. But, as it had happened, scientific discourse—in this case psychiatry—was not independent of political and social agendas, and suicide was often linked to degeneration and immoral behaviour in general. This was no surprise either: psychiatry had emerged during an era in which the buzzword was 'struggle for existence' and nations were trying to get ahead of each other by cultivating physically, psychologically and morally fit citizens.[43] Yes, suicide had been turned into an object of scientific and medical study, but it did not necessarily mean that suicide as an illness was free of moral biases.

As the modern suicidology began to take form in Southern California and Austria in the late 1950s, suicide was labelled as a 'public health problem',[44] which changed the status of suicide from a sign of degeneration or a plight of a marginal section of the population into a medical subject with large-scale significance. As the new generation of Finnish psychiatrists with a background in psychodynamics took positions in academic psychiatric institutions, some of them turned their attention to suicide. The Finnish suicidologists cultivated a strong working relationship with their international colleagues. By the 1970s, Farberow, Shneidman and Ringel had all worked together with the Finnish suicidologists, and their writings were regularly published in psychiatric and medical journals in Finland. Furthermore, Farberow acted as a teacher on a suicide prevention course in Finland in 1974, and he also participated in several seminars and conferences on suicide prevention held in Finland during the 1970s.[45]

As there was only a small chance to identify suicidal individuals beforehand, one of the first suicide prevention methods internationally was to provide suicide candidates with an opportunity to reach for

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[43] Petteri Pietikäinen, *Madness: A History* (London: Routledge, 2015), 126–29; Scull, *Madness*, 245–46; Roger Smith, *Between Mind and Nature: A History of Psychology* (London: Reaktion Books, 2013), 107, 112.

[44] Shneidman, Farberow, and Litman, "Suicide Prevention," 6.

[45] Myllykangas, *Rappeutuminen*, 157.

help. Following the example of a phone helpline by the Samaritans in England, the first phone service was established in Helsinki in 1964.[46] The next step to be taken was the establishing of the SOS-Service Suicide Prevention Center in Helsinki in 1970. SOS-Center was formed under the supervision of the Finnish Association of Mental Health, and the organisation of the centre followed the example of the Suicide Prevention Center in Los Angeles. The activities included acute crisis help, public education and suicide research. During the first nine months of the SOS-Center's phone helpline between April 1970 and December 1970, the service received 2797 calls, roughly 10 calls per day.[47] In comparison, 272 suicides were committed in Helsinki in 1970–1971.[48]

The paradigm shift of suicide research in the 1960s included a new conceptualisation of suicide. In 1967, psychiatrist Kalle Achté (b. 1928), who was to become one of the most prominent suicide researchers in Finland, underlined in an article tellingly titled 'Are suicides preventable?' how suicide had used to be seen as 'nature's process of purging itself' and how this kind of understanding should be regarded as primitive. He noted how the development of psychiatry and the rising interest in mental health in general had made suicide topical. Also, the fact that the suicide rate in Finland had eventually reached an internationally high level meant that the suicide phenomenon needed to be systematically scrutinised.[49] The research aspect was being taken care of by an unprecedented surge in psychiatric research activity during the late 1960s and 1970s. The Finnish suicidologists produced dozens of journal articles, as well as edited volumes, in their attempt to study every aspect of suicide available to the imagination. Psychodynamic psychiatry presented the conceptual framework, in which the depressed habitus or aggressive behaviour of various suicidal subgroups was analysed.[50] In regard to wider psychiatric and medical discourse, the emergence of suicide prevention discourse *as such* sprang from the post-Second World War discourse of preventative medicine.

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[46] Kalle Achté, "Voidaanko itsemurhia ehkäistä?" *Medisiinari*, no. 7 (1967): 46–47.

[47] Veikko Aalberg, "SOS-Service, The Suicide Prevention Center in Helsinki," *Psychiatria Fennica* (1971), 247–50.

[48] Jouko Lönnsvist, *Suicide in Helsinki* (Helsinki: Psychiatria Fennica, 1977), 98.

[49] Achté, "Voidaanko," 45.

[50] Myllykangas, *Rappeutuminen*, 154–59, 166–74.

Regarding policymaking, the prevention of suicide was at the core of suicide discourse. As the new generation of suicide researchers had raised the awareness of the gloomy national condition, the early 1970s first saw governmental actions taken in regard to diminishing the numbers of suicides in Finland, which had climbed to over 20 suicides per 100,000 inhabitants.[51] Finland was reported to hold the fifth place in the world suicide statistics, and it seemed that only the relatively small numbers of women committing suicide in Finland was stopping Finland from reaching the top, as Finnish men committed suicide second most frequently in the world (Hungarian men had the questionable honour to hold the first place).[52] As the new data concerning the suicide situation in Finland began to surface, the Ministry of Social Affairs and Health appointed a suicide committee to assess the suicide situation and presented guidelines for suicide prevention in 1973–1974. The committee deemed current knowledge of the suicide situation in Finland to be insufficient, and proposed the provision of more psychiatric counselling opportunities in general hospitals and health centres.[53]

The fact that suicide was—despite its complicated social significance—an act committed by an individual was often buried under regional and national statistics and general guidelines. The epidemiology of suicide begun to be better understood as the psychiatrist Jouko Lönnqvist (b. 1943) released a social psychiatric study of suicides committed in Helsinki between 1960 and 1970. One of his major conclusions was that a statistically driven epidemiological study of suicide could not explain why suicides were committed, and thereby research should move towards small groups and individual levels.[54] And, as a testimony to the dynamic nature of the new wave of Finnish suicide research of the 1960s, Lönnqvist's theoretically oriented discussion did not fall into obscurity. On the contrary, the individual suicide case was put in the spotlight in a genuinely groundbreaking suicide prevention project during the late 1980s.

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[51] Jouko Lönnqvist, "On the Epidemiology of Suicide in Finland," in *Suicide Research*, eds. Kalle Achté and Jouko Lönnqvist (Helsinki: Psychiatria Fennica, 1976), 75.

[52] Pirkko Idänpää-Heikkilä, "Itsemurhan psykodynamiikasta," *Suomen Lääkärilehti*, no. 25 (1971): 1526–30.

[53] Sosiaali- ja terveysministeriö, *Itsemurhatoimikunnan mietintö* (Helsinki: Sosiaali- ja terveysministeriö, 1974), 57–58, 76.

[54] Lönnqvist, *Suicide*, 156.

In the mid-1980s, following the WHO strategy 'Health for All by 2000', Finland was the first country in the world to execute a nationwide research project on suicide and began to develop suicide prevention guidelines for social and medical professionals. Jouko Lönnqvist acted as one of the psychiatric experts and project leaders of the National Suicide Prevention Project (NSPP), conducted in 1986–1996. In the NSPP, the imperfections in suicide statistics were complemented by performing a 'psychological autopsy' on every suicide and on all unclear cases of death that had taken place in Finland between 1987 and 1988.[55] This part of the project alone brought together 450 professionals to study the suicide problem.[56] The goal of NSPP was, for one part, to overcome the shortcomings of statistically oriented research by gathering as much background information on each suicide case as possible and thereby to build a more complete understanding of the suicide phenomenon.[57] As the emerging suicidology in the 1960s and 1970s had begun to generate an understanding on how complex the suicide phenomenon actually was, NSPP further elaborated the late twentieth-century understanding of suicide. Suicide was no longer understood in relation to a single abnormality, for example in a framework of mental illness, but professionals regarded psychiatric, psychological, social and societal factors as essential in understanding the suicide process and how to prevent it.[58]

NSPP produced a set of guidelines for medical and social work professionals to help them to identify individuals who were at risk of committing suicide. Aside from a so-called 'early intervention' aspect, following the principle of primary prevention, the project formulated a plan of action to create a mentally and socially supportive environment, which reflected the multifaceted understanding of the suicide process. This included tackling issues such as social exclusion and the meaning

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[55] Maila Upanne, *Professional Paradigms of Suicide Prevention* (Helsinki: Stakes, 2001), 14.

[56] Ministry of Social Affairs and Health, *Suicide Prevention in Finland 1986–1996: External Evaluation by an International Peer Group* (Helsinki: Ministry of Social Affairs and Health, 1999), 9.

[57] Jouko Lönnqvist et al., "Itsemurhat Suomessa 1987 -tutkimusprojekti," in *Itsemurhat Suomessa 1987 -projekti*, eds. Jouko Lönnqvist, Hillevi Aro, and Mauri Marttunen (Helsinki: Stakes, 1993), 4.

[58] Upanne, *Professional Paradigms*, 3–4.

of suicide as a part of the Finnish concept of manliness.[59] A key feature of new suicide prevention guidelines was to advice professionals to take early signs of self-destructiveness seriously.[60] In practice, the Finnish project reiterated many of the warnings and advice formulated by Shneidman and Farberow in the early 1960s.

Regarding one of the major obstacles of suicide prevention, the taboo aspect of suicide, the project was seen as a success as it was thought that by the late 1990s talking about suicide and reaching for help had become more acceptable and the suicide problem was dealt with in a more open manner.[61] More generally, in the late 1990s and early 2000s, public culture became more accepting towards discussion of personal mental health issues in Finland. During that time, several Finnish public figures published 'memoires of madness' or opened up in interviews about their mental disorders. Usually, the disorders fell into the depression category or were labelled as 'burnout'.[62] However, despite the advancements on the social and cultural sides of suicide discourse, one of the more lasting effects of NSPP has been the new-found connection between mental illness and suicide, especially with depressive disorders.

The Depression Paradigm and Beyond: Suicide Prevention in the Third Millennium

In the history of late-twentieth-century psychiatry in Finland, the NSPP has been connected to the emergence of 'depression discourse' of the 1990s. As the project underlined the co-existence of mental disorders and, particularly, depression with suicidal behaviour, it has been argued that the connection of suicide risk with depression drew attention to the study and treatment of depressive disorders.[63] The definition of mental

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[59] Sosiaali- ja terveyshallitus, *Itsemurhan voi ehkäistä* (Helsinki: Sosiaali- ja terveyshallitus, 1992), 14, 22–23.

[60] Jouko Lönnqvist, "Suicide Prevention in Finland," in *Oxford Textbook of Suicidology and Suicide Prevention*, eds. Danuta Wasserman and Camilla Wasserman (Oxford: Oxford University Press, 2009), 794.

[61] Jari Hakanen and Maila Upanne, *Itsemurhien ehkäisyn käytännöt Suomessa* (Helsinki: Stakes, 1999), 143; Ministry of Social Affairs and Health, *Suicide Prevention*, 11.

[62] See e.g. Tellervo Koivisto, *Päiväkirjan uudet sivut* (Helsinki: Otava, 1999); Neil Hardwick, *Hullun lailla*, trans. J. Lindholm (Helsinki: Otava, 1999).

[63] Ilpo Helén, Pertti Hämäläinen, and Anna Metteri, "Komplekseja ja katkoksia," in *Reformin pirstaleet*, ed. Ilpo Helén (Tampere: Vastapaino, 2011), 36.

disorders employed in NSPP was extremely broad ('any psychic syndrome with subjective suffering and/or self-destructive behaviour'), and following this broad definition, 93% of the examined suicides were given a psychiatric diagnosis. Two-thirds were some sort of depressive disorders.[64] During the 1990s, the co-existence of depression and suicidal behaviour was further highlighted in Finnish and international studies.[65] However, the causal relationship between suicide and rising anxiety over depression might be more complicated.

Internationally, the last decades of the twentieth century were an era of upheaval in psychiatric theory. The changes in psychiatric paradigm towards neurobiology following DSM-III in 1980 and the subsequent editions and almost simultaneous introduction of SSRI antidepressants transformed the concept of depression from a reaction to life-events to a chemical disorder.[66] Changes in the psychiatric discourse have also impacted the conception of suicide. Dan Blazer has pointed out how the medicalisation of depression has lessened the interest in the primary prevention of depression, as the current paradigm sees depression as a symptom of biological vulnerability.[67] It appears that something similar has also happened in the suicide discourse following the medicalisation of depression and, by proxy, of suicide.

Regarding the Finnish psychiatric suicide discussion of the last two decades, depression and antidepressant medication are the two constant nominators in explaining and preventing suicides. The boundaries between primary prevention and early intervention become fuzzy as the risk of suicide is closely associated with patients suffering from depression, which is stated as a reason for prescribing antidepressant medication.[68] Here, the Finnish suicide discourse has jumped on the bandwagon of preventing suicide through antidepressant medication.

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[64] Markus Henriksson et al., "Mielenterveyden häiriöt ja itsemurha," in *Itsemurhat Suomessa 1987 –projekti*, eds. Jouko Lönnqvist, Hillevi Aro, and Mauri Marttunen (Helsinki: Stakes, 1993), 70–71.

[65] See e.g. Kirsi Suominen et al. "Mental Disorders and Comorbidity in Attempted Suicide," *Acta Psychiatria Scandinavica* 94, no. 4 (1996): 234, 237; Timo Partonen, Jari Haukka, and Jouko Lönnqvist, "Itsemurhakuolleisuus Suomessa vuosina 1979–2001," *Duodecim* 119 (2003): 1827.

[66] Scull, *Madness*, 388–90, 404.

[67] Dan Blazer, *The Age of Melancholy* (New York: Routledge, 2006), 10.

[68] See e.g. Kirsi Suominen and Hanna Valtonen, "Itsetuhoisen potilaan arviointi," *Duodecim* 129 (2013): 884–85; Pia Solin and Timo Paronen, "Tunnista itsemurhan vaara!" *Duodecim* 133 (2017): 1409–10.

In 2000, Swedish psychiatrist Göran Isacsson asked what seemed to be a rhetorical question: 'Suicide prevention—a medical breakthrough?' By comparing Swedish suicide rates and the antidepressant sales statistics, he concluded that the increasing use of antidepressant medication was the only factor that could conclusively explain the decrease in the suicide rate in Sweden during the time period of a fluctuating economy and other social factors that have been associated with changes in suicide rates.[69] Isacsson's observation was further studied during the 2000s, and it seemed that antidepressant medication finally provided an answer to the suicide problem.[70] As it happened, the Finnish suicide rate declined drastically during and after the implementation of NSPP: In 1990, the Finnish suicide rate was 30.37, and by 2016, it had lowered to c. 14.3.[71] Around the same time, the consumption of antidepressants also increased in Finland, and likewise, the mass-medication of depression was seen as a promising method to prevent suicides.[72] Some studies attempted to show how the suicide rate had fallen in those areas of Finland where the use of medication was most common between 1994 and 2001, thereby providing evidence on the significance of medication in combating the suicide problem, even though it was also acknowledged that in areas where the use of antidepressant medication was low (in the Eastern and Northern part of Finland), there were also many more social problems, including unemployment.[73]

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[69] Göran Isacsson, "Suicide Prevention—A Medical Breakthrough," *Acta Psychiatria Scandinavica* 102, no. 2 (2000): 113.

[70] Göran Isacsson et al., "Decrease in Suicide Among the Individuals Treated with Antidepressants," *Acta Psychiatria Scandinavica* 120, no. 1 (2009): 37–44; Svein Reseland, Isabella Bray, and David Gunnell, "Relationship Between Antidepressant Sales and Secular Trends in Suicide Rates in the Nordic Countries," *British Journal of Psychiatry* 188 (April 2006): 355–56; Hans-Jürgen Möller, "Pharmacological and Other Biological Treatments of Suicidal Individuals," in *Oxford Textbook of Suicidology and Suicide Prevention*, eds. Danuta Wasserman and Camilla Wasserman (Oxford: Oxford University Press, 2009), 398–99.

[71] Partonen, Haukka, and Lönnqvist, "Itsemurhakuolleisuus," 1830; Official Statistics of Finland (OSF), *Causes of Death* [e-publication], ISSN = 1799-5078 (2016): 6, http://www.stat.fi/til/ksyyt/2016/ksyyt_2016_2017-12-29_kat_006_en.html.

[72] Jari Holopainen, Samuli Helama, and Timo Partonen, "Suomalainen itsemurhakuolleisuus 1950–2009 eurooppalaisessa vertailussa," *Duodecim* 130 (2014): 1536–44 (1543).

[73] Jyrki Korkeila et al., "Use of Antidepressants and Suicide Rate in Finland," *Journal of Clinical Psychiatry* 68, no. 4 (May 2007): 505–11 (506–8).

However, some researchers pointed out that even without taking socio-economic factors into consideration, the use of antidepressants in suicide prevention appears to be problematic. In 2006, a Finnish research group stated, based on a patient sample of 15,390, that 'the risk of suicide attempts is definitely increased during all antidepressant treatments, when compared with no antidepressant use'. Furthermore, they argued that '[d]espite extensive research, it has not been possible to demonstrate that the use of any antidepressant medication decreases the risk of suicide'.[74] These kinds of sceptical voices[75] towards SSRI-medication for suicide prevention (and in the treatment of depression in general) have also generated a backlash from pharmacologically oriented psychiatry. Hesitance in prescribing antidepressants to adolescents is now seen as a possible risk to the increase in suicides in the future,[76] although in late 2010s a British research group stated that they had found no correlation between antidepressant prescription trends and adolescent suicide rates.[77]

Conclusion

The Western suicide prevention discourse of the early twenty-first century is suspended between two historically familiar poles. The biological explanations of suicide have re-emerged through the framework of psychopharmacology and deepening understanding of neurology and genetics. On the other hand, the sociocultural and environmental approach that emerged during the social psychiatry dominated 1970s has not completely disappeared. The significance of the social environment and community mental health services is still brought up as having an impact on suicide rates. In 2009, studying socio-economic differences in different areas in Finland and how they correlated with suicide figures, researchers

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[74] Jari Tiihonen et al., "Antidepressants and the Risk of Suicide, Attempted Suicide, and Overall Mortality in a Nationwide Cohort," *Archives of General Psychiatry* 63 (December 2006): 1358–67 (1358, 1362).

[75] See e.g. David Healy, Kim Bechthold, and Peter Tolias, "Antidepressant-Induced Suicidality," *Personalized Medicine* 11, no. 1 (2014): 79–88.

[76] Mauri Marttunen and Henna Haravuori, "Nuorten masennuslääkehoito ja itsetuhoisuus" [editorial], *Duodecim* 131 (2015): 613–14.

[77] Benedict W. Wheeler et al., "The Population Impact on Incidence of Suicide and Non-Fatal Self Harm of Regulatory Action Against the Use of Selective Serotonin Reuptake Inhibitors in under 18s in the United Kingdom: Ecological Study," *British Medical Journal* 336 (2008): 542–45.

found that 'societal disturbances, for example violence, [high] alcohol sales, and unemployment, were strongly linked to an increased need for inpatient services to prevent suicides'.[78] However, as a departure from the familiar debate between biological and social, a synthesis is emerging in the international suicide discourse. According to the 'stress-vulnerability model', the fact that only a few per cent of depressed individuals are suicidal is taken into account and mental disorders like depression are seen only as a part of the stressors that include life experiences, traumas and illnesses. At the core of the model is a 'suicidal brain' that reacts self-destructively to stressful life experiences. Identification of this trait-like 'suicidal brain' sounds rather straight forward, but the genetic influence on suicide process is considered 'complex' due to its polygenetic nature and the interaction of the genetic biological background and preventive and risk factors in the environment through lifetime.[79] However, what stands out here in regard to the history of suicide research and prevention is the willingness to approach suicide as multifaceted phenomenon rather than a symptom of a singular biological or psychological disorder. Similarly, in a recent suicide prevention strategy by the United States health administration, it was underlined that suicide should not be regarded solely as a psychiatric issue, and successful prevention would require a holistic approach.[80] Nevertheless, as in the past, whichever method of suicide prevention is regarded as the best, it appears as a practical extension of the underlying theoretical conception of suicide. Due to the complex nature of the problem, it is unlikely that any approach by itself would manage to solve the mystery of suicide. As long as the conflicting viewpoints of socially oriented suicide research, neuropsychological studies and neurochemical research are not brought together in a meaningful way, it is unlikely that a phenomenon that can be measured and studied on a population level, but which manifests under uniquely individual circumstances, will be definitively explained, let alone prevented.

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[78] Sami Pirkola et al., "Community Mental Health Services and Suicide Rate in Finland," *Lancet* 373 (January 2009): 147–53.

[79] Danuta Wasserman and Marcus Sokolowski, "Stress-Vulnerability Model of Suicidal Behaviours," in *Suicide: An Unnecessary Death*, ed. Wasserman, 21–22.

[80] Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention* (Washington, DC: Department of Health and Human Services, 2012), 11, 13, 21.

CHAPTER 8

Risk Assessment in an Age of Neoliberalism: John Monahan's *The Clinical Prediction of Violent Behavior* (1981)

Matthew Gambino

Introduction

Prevention has taken many forms in mental healthcare over the past century, ranging from progressive social welfare policies to coercive measures aimed at controlling the reproduction of men and women deemed unfit. The guiding assumption of such work has been that through the judicious administration of expert knowledge, the personal suffering and social chaos engendered by mental illness might be reduced in both frequency and intensity. And yet for most mental health providers today, nearly all of the patients they serve have already been identified as having a psychological disorder or problem of some kind. In this context, prevention assumes a different meaning: reducing the likelihood of future decompensation, particularly of the sort that is likely to result in violence against oneself or others. Here we are discussing not prevention of mental illness per se, but of the more dramatic and damaging sequelae with which it is associated.

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In this essay, my focus is on a single moment in the evolution of mental health providers' approach to the management of violence risk among their patients. John Monahan's *The Clinical Prediction of Violent Behavior* (1981) was a slim but widely influential monograph, rapidly recognised as a central text in the emerging field of risk assessment.[1] By attending exclusively to the question of interpersonal violence, I am setting aside a parallel literature on suicide risk that has been equally influential over the course of the past half-century. As public attention turns again to the question of links between mental illness and mass violence, however, it seems like a particularly propitious time to consider the origins of risk assessment. I will argue that Monahan's text represents a key point in the evolution of psychiatric practice in the post-World War II era, one from which we can read out to identify the major ideological currents at work in this period. The historiography of psychiatry in the 1960s, 1970s, and 1980s has been dominated by accounts of the tension between biological and psychodynamic perspectives on mental illness. While not unimportant, I suggest that such an approach has led us to neglect other currents that are just as central to an understanding psychiatry and its social role.

The Path to Risk Assessment

Born in New York and raised on Long Island, John Monahan was the son of a police officer who discouraged him from following in his footsteps. Following several years in seminary as an aspiring Catholic priest, Monahan transitioned to the State University of New York at Stonybrook. After reading Carl Rogers' *On Becoming a Person* (1961), he pursued a degree in psychology, and then moved on to graduate studies at Indiana University. There his doctoral research focused on the role of self-attribution in behaviour change, though he also took several courses in the law school. Facing the draft and needing to complete his clinical training, Monahan enlisted in the Army's Medical Service Corps and secured an internship at the Letterman Army Medical Center in San Francisco. Monahan struggled with his assigned task of discerning authentic illness from malingering among soldiers who faced deployment to Vietnam. After six months, he shifted to a different site, the Courts

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[1] John Monahan, *The Clinical Prediction of Violent Behavior* (Washington, DC: Government Printing Office, 1981).

and Corrections Unit at the San Mateo County Department of Public Health and Welfare, where he was involved in competency evaluations, civil commitment proceedings and insanity defence cases. This experience consolidated his interest in work at the intersection of psychology and the law. In 1972 Monahan secured a position in the Program in Social Ecology at the University of California at Irvine, where he worked alongside criminologists, lawyers and sociologists to address socially relevant problems.[2]

This was a period of rapid change in U.S. mental healthcare, during which psychiatry in particular was experiencing what historian Charles Rosenberg described as a 'crisis of legitimacy.'[3] The broader critique of authority that marked the long 1960s led many to question both psychiatry's scientific pretensions and its ostensibly humanistic aspirations, calling attention instead to its role in the enforcement of conservative social norms.

Deinstitutionalisation was already well underway, sparked by the advent of new forms of drug treatment and the emergence of the community mental health movement. Critics viewed public hospitals as regressive sites of abuse, neglect and oppression, inspired in part by works such as Erving Goffman's *Asylums* (1961).[4] The actual downsizing of state hospital populations, however, was due in large measure to shifts in health policy encouraging the transfer of elderly residents to nursing homes (where they would be supported at federal rather than state expense) and new social welfare measures providing entitlements to seriously mentally ill men and women in the community.[5]

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[2] Author's interview with John Monahan (11 May 2016); Monahan, "Predictions of Violence," in *The Roots of Modern Psychology and Law: A Narrative History*, eds. Thomas Grisso and Stanley L. Brodsky (New York: Oxford University Press, 2018), 147–48.

[3] Charles Rosenberg, "The Crisis of Psychiatric Legitimacy: Reflections on Psychiatry, Medicine, and Public Policy," in *American Psychiatry: Past, Present, and Future*, eds. George Kriegman, Robert D. Gardner, and D. Wilfred Abse (Charlottesville: University Press of Virginia, 1975), 135–48.

[4] Michael E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948–1980* (Chicago: University of Chicago Press, 2011), 67–87. See also Matthew Gambino, "Erving Goffman's *Asylums* and Institutional Culture in the Mid-Twentieth-Century United States," *Harvard Review of Psychiatry* 21, no. 1 (2013): 52–57.

[5] Gerald N. Grob and Howard H. Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* (New Brunswick, NJ: Rutgers University Press, 2006), 47–53.

Libertarian impulses animated progressive political discourse in the 1960s and 1970s, emphasising personal autonomy and freedom from unwarranted intrusions of state authority. In this context, mental health law became a particularly contentious field of debate. Issues of individual freedom and responsibility were played out in a wide variety of cases, linked thematically by a shared scepticism towards psychiatry's claim to social authority.[6] Nowhere was this convergence of civil liberties activism and anti-psychiatric sentiment clearer than in the work of attorney Bruce Ennis, director of the Civil Liberties and Mental Illness Litigation Project in New York City. In a seminal law review article he authored with psychologist Thomas Litwack, Ennis compared reliance upon psychiatric testimony in matters of civil commitment to 'flipping coins in the courtroom.'[7] An increasing number of judges and legislators agreed.

Against this backdrop, three developments in particular set the stage for Monahan's work on violence prediction. The first involved changing standards for civil commitment. Previously, involuntary hospitalisation had been justified on the basis of an ill-defined 'need for treatment.' Beginning in the 1960s, however, legislators and the courts turned to the police powers of the state to justify abridgment of individual liberties rather than their historic reliance on *parens patriae*.[8] The federal government passed one of the earliest such statutes for the District of Columbia in 1964, restricting civil commitment to those mentally ill persons deemed dangerous to themselves or others. California's Lanterman–Petris–Short (LPS) Act, passed in 1967 and implemented two years later, adopted a similar standard, though it also included a provision for those deemed so gravely disabled that they could not meet their basic physical needs. In *Lessard v. Schmidt* (1972), a federal district court in Wisconsin concluded that civil commitment was justifiable only on the grounds of imminent dangerousness, and in *O'Conner v. Donaldson* (1975) the U.S. Supreme Court affirmed the unconstitutionality of detention for non-dangerous individuals capable of caring for themselves. By the end

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[6] Gerald N. Grob, "The Attack of Psychiatric Legitimacy in the 1960s: Rhetoric and Reality," *Journal of the History of the Behavioral Sciences* 47, no. 4 (2011): 407–9.

[7] Bruce J. Ennis and Thomas R. Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," *California Law Review* 62, no. 3 (1974): 693–752.

[8] Judith Lynn Failer, *Who Qualifies for Rights? Homelessness, Mental Illness, and Civil Commitment* (Ithaca, NY: Cornell University Press, 2002), 71–87.

of the 1970s, every state had either interpreted its laws in a manner consistent with these findings or introduced new statutes along similar lines.[9]

The second development involved changing ideas in penal policy and waning faith in mental health professionals' ability to identify truly dangerous individuals. Rehabilitative models of incarceration came under fire in the 1970s from both the right and the left; conservatives favoured a harsher approach based purely on punishment, while progressives saw indeterminate sentencing as introducing ambiguity and the potential for systemic bias where transparency should reign. California's determinate sentencing legislation in 1976 was the first among many to reduce the discretion of judicial officials and parole officers when it came to the time offenders spent behind bars.[10] Meanwhile, a consensus had emerged about mental health providers' inability to discern dangerous recidivists from those who were unlikely to represent a threat in the future, leaving officials with little guidance in matters of parole. Several landmark studies in the late 1960s and early 1970s followed offenders who had been deemed dangerous by mental health providers, including a series of patients transferred from forensic to civil settings in New York after the courts concluded in *Baxstrom v. Herold* (1966) that mentally ill prisoners who had served their sentences could not be detained further without civil commitment proceedings. These studies found that mental health providers wildly overestimated the dangerousness of their patients.[11]

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[9] Paul S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (New York: Oxford University Press, 1994), 17–29. For the broader context of reform through litigation, see Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981), 113–39.

[10] Julilly Kohler-Hausmann, *Getting Tough: Welfare and Imprisonment in 1970s America* (Princeton, NJ: Princeton University Press, 2017), 216–21, 231–49, 258–75; Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007), 88–90.

[11] Henry J. Steadman and Joseph J. Cocozza, *Careers of the Criminally Insane: Excessive Social Control of Deviance* (Lexington, MA: D. C. Heath, 1974). See also Harry L. Kozol, Richard J. Boucher, and Ralph F. Garofalo, "The Diagnosis and Treatment of Dangerousness," *Crime and Delinquency* 18, no. 4 (1972): 371–92; Henry J. Steadman, "A New Look at Recidivism Among Patuxent Inmates," *Bulletin of the American Academy of Psychiatry and the Law* 5, no. 2 (1977): 200–9; Joseph E. Jacoby and Terence P. Thornberry, *The Criminally Insane: A Community Follow-up of Mentally Ill Offenders* (Chicago, IL: University of Chicago Press, 1979); Cocozza and Steadman, "The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence," *Rutgers Law Review* 29, no. 5 (1976): 1084–1101.

Within a few years, both the American Psychiatric Association and the American Psychological Association had concluded that predictions of violence were empirically suspect, ethically fraught, and more likely than not to be inaccurate.[12]

The third development occurred in the unlikely domain of tort law. In October 1969, Prosenjit Proddar, an Indian graduate student at the University of California at Berkeley killed a female acquaintance, Tatiana Tarasoff, with whom he had been infatuated. Proddar had previously been in therapy, and several months earlier his psychologist had become sufficiently concerned about Proddar's thinking that he alerted campus police and requested his detention. The police, however, detected no evidence of irrationality or threat, and after eliciting a promise to stay away from Tarasoff, let Proddar go. Tarasoff's parents sued the University of California, alleging negligence in failing to detain Proddar or alert them or their daughter of the threat. In their decision in 1974 and then again in 1976, the California Supreme Court sided with the parents, identifying a duty to intervene on the part of mental health providers when a patient represented a direct threat to others. Courts and legislatures outside of California were initially slow to adopt a similar standard, but the impact of the case was still substantial. Suddenly violence prediction was no longer solely the domain of forensic specialists. Instead, it was the task of everyday practitioners whose training did not necessarily prepare them for such a responsibility. Critics predicted that the duty to intervene—whether to warn the potential victim or involve the police—would compromise the psychotherapeutic relationship, based as it was on the promise of confidentiality, and discourage those who needed help most from seeking it.[13]

Monahan followed these developments closely, and each informed his early work. In 1972, Monahan's psychiatric colleague Marc Abramson warned of some of the unintended consequences of the newly restrictive

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[12] "American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual," *Clinical Aspects of the Violent Individual* (Washington, DC: American Psychiatric Press, 1974); American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, "Report of the Task Force on the Role of Psychology in the Criminal Justice System," *American Psychologist* 33, no. 12 (1978): 1099–1113. Monahan chaired the latter group.

[13] Alan A. Stone, "The Tarasoff Case and Some of Its Progeny: Suing Psychotherapists to Safeguard Society," in *Law, Psychiatry, and Morality: Essays and Analysis* (Washington, DC: American Psychiatric Press, 1984), 161–64; Appelbaum, *Almost a Revolution*, 71–113.

criteria for civil commitment in California, arguing that mentally ill individuals were being inappropriately shunted into the criminal justice system rather than the mental health system.[14] Monahan responded by defending the California statute, suggesting that deviant behaviour was best dealt with in the courts, where society's level of tolerance for such conduct could be debated openly and individuals were accorded rights of due process that were often lacking in the mental health system.[15] Three years later, in one of his earliest publications on the violence prevention, Monahan reviewed the literature and concluded that psychiatric predictions involved an unacceptably high rate of false positives.[16] The California Supreme Court specifically cited Monahan's piece in *Tarasoff*, though ultimately the justices found this unconvincing as a reason for providers not to intervene when they suspected imminent risk.[17]

Citation in *Tarasoff* solidified Monahan's reputation as an emerging authority in matters of violence prediction. Given the steadily rising rate of violent crime, as well as the growing ferment at the intersection of mental health policy and the law, Monahan saw an opportunity to make his mark in an increasingly important but still underdeveloped field. During 1976–1977, he spent a year as a fellow at Harvard Law School, where he both learned from and collaborated with the legal scholar Alan Dershowitz (a critic of psychiatric involvement in the criminal justice system) and the eminent psychiatrist Alan Stone (a critic of contemporary efforts to restrict the basis for civil commitment). The following year, while at Stanford Law School, he co-taught a seminar with psychologist David Rosenhan, whose widely publicised critique of psychiatric diagnostics had embarrassed the profession several years earlier.[18]

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[14] Marc F. Abramson, "The Criminalization of Mentally Disordered Behavior: Possible Side-Effects of a New Mental Health Law," *Hospital & Community Psychiatry* 23, no. 4 (1972): 101–5.

[15] John Monahan, "The Psychiatrization of Criminal Behavior: A Reply," *Hospital & Community Psychiatry* 24, no. 2 (1973): 105–7.

[16] John Monahan, "The Prevention of Violence," in *Community Mental Health and the Criminal Justice System*, ed. John Monahan (New York: Pergamon Press, 1976), 13–34.

[17] *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976).

[18] Author's interview with Monahan; Monahan, "Predictions of Violence," 149. On Rosenhan's classic experiment and its impact, see Staub, *Madness Is Civilization*, 178–79, 182–83, 186.

Monahan authored or co-authored a series of articles in this period on violence prediction, civil commitment, the culpability of mentally disordered offenders, and historical and philosophical perspectives on dangerousness.[19] He also participated in state and federal hearings on sentencing reform.[20] This work brought him to the attention of Saleem Shah, chief of the Center for Studies of Crime and Delinquency at the National Institute of Mental Health (NIMH). Shah became a mentor and colleague to Monahan, and soon offered him a commission to write the monograph that would become a classic in the field.[21]

THE CLINICAL PREDICTION OF VIOLENT BEHAVIOUR

Monahan adopted an avowedly practical approach in the work, setting out to 'assist the practicing mental health professional in understanding the issues involved in violence prediction and so to improve the appropriateness and accuracy of his or her clinical predictions.'[22] Monahan chose his words carefully, preferring 'violence' to 'dangerousness,' which he felt was too vague and assumed the existence of an indelible trait rather than attending to aspects of a person's behaviour in future situations. As he acknowledged in his preface, Monahan's thinking had evolved considerably over the course of the 1970s. He had started out agreeing with many of his peers that clinical prediction of violence was not empirically possible, and that even if it was, it would be an ethically suspect undertaking. Gradually, however, he began to believe that

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[19] John Monahan, "The Prediction of Violence," in *Violence and Criminal Justice*, eds. Duncan Chappell and John Monahan (Lexington, MA: Lexington Books, 1975), 15–31; Monahan and Leslie Cummings, "The Prediction of Dangerousness as a Function of Its Perceived Consequences," *Journal of Criminal Justice* 2, no. 3 (1974): 239–42; Monahan and Gilbert Geis, "Controlling 'Dangerous' People," *Annals of the American Academy of Political and Social Science* 423, no. 1 (1976): 142–51; John Monahan and Gloria L. Hood, "Psychologically Disordered and Criminal Offenders: Perceptions of Their Volition and Responsibility," *Criminal Justice and Behavior* 3, no. 2 (1976): 123–34; John Monahan, "John Stuart Mill on the Liberty of the Mentally Ill: An Historical Note," *American Journal of Psychiatry* 134, no. 12 (1977): 1428–29.

[20] Monahan, "Predictions of Violence," 148; John Monahan, "Dangerousness and Civil Commitment," in Committee on the Judiciary, United States Senate, *Reform of the Federal Criminal Laws* (Washington, DC: Government Printing Office, 1974), 7083–93.

[21] Author's interview with Monahan.

[22] Monahan, *Clinical Prediction of Violent Behavior*, v.

specific and limited forms of prediction were both valid and appropriate. Above all, he sought to bring a measure of clarity to the field, and to overcome the tendency for providers to rely on vague and inchoate notions of 'clinical judgment.' In the process, he hoped to formally articulate the standards clinicians were using, and to lay the groundwork for future research.

The clinical prediction of violent behaviour, Monahan argued, must be based on a thorough assessment of individual variables, situational variables and the interaction between the two. He criticised clinicians for their tendency to focus on factors located in the patient at the expense of the social environment in which he or she would be operating. Monahan similarly called attention to clinicians' tendency to privilege case-based information, leading them to neglect the base rate of violence in the population—'the single most important piece of information necessary to make an accurate prediction' (34). Returning to the recent studies of populations deemed dangerous but released to non-carceral settings, Monahan concluded that 'the "best" clinical research … indicates that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several-year period among institutionalized populations that had both committed violence in the past (and thus had high base rates for it) and who were diagnosed as mentally ill' (60).

Monahan drew upon both clinical and actuarial approaches to violence prediction, acknowledging the merits of each. In the clinical approach, conclusions were based on a synthesis of information gathered from interviews, history and possibly psychometric exams; in the actuarial approach, information was combined to arrive at an empirically determined relative frequency. As Monahan pointed out, these perspectives represented ends of a continuum, and in practice most instances of prediction drew upon both. Surveying the literature, he identified six major statistical correlates of violent behaviour: past crime, particularly violent crime; age; sex; race; socio-economic status and employment stability; and opiate or alcohol abuse. In general, he noted, actuarial predictions tended to be more accurate, but their legitimacy was not universally accepted. Monahan acknowledged that clinical approaches might be superior when dealing with rare factors that could not be anticipated in actuarial tables or in short-term emergency scenarios where data did not yet exist. In order to improve prediction, he suggested, clinicians needed to know the base rate of violence in the population to which an individual belonged, obtain data on factors that were actually related to future violence and not overreact to one positive indicator of future violence at the expense of several negative ones. He went on to make the case for incorporating environmental context into predictions, suggesting that clinicians consider how an individual might respond in a set of hypothetical situations, and how likely he or she was to encounter such situations.

Ethical considerations were never far from the surface of Monahan's work. He recognised the biases and contradictions of the system within which violence prediction occurred. The focus on street crime and interpersonal violence carried with it an implicit class bias that rendered offences such as corporate malfeasance and large-scale fraud invisible. The use of apparently robust risk factors like race and socio-economic status, moreover, placed already disadvantaged groups at a further disadvantage. Such factors might statistically increase the likelihood of future violence, but the fact that they existed outside the bounds of an individual's control called into question their admissibility in a medico-legal context, or indeed whether they might actually reduce an individual's culpability. Even historical episodes of violent conduct—the most consistent and powerful predictor of future violence—raised troubling questions. Was it morally acceptable to use prior crimes to predict future crimes if the offender had already paid his or her due?

Monahan also struggled with whether it was even ethically permissible for a member of the healing professions to engage in violence prediction. Some argued that by accepting the legal system's mandate to opine on matters of violence potential, psychiatrists and psychologists had abandoned their mission to alleviate psychic suffering and had instead become agents of social control. Responding to this line of criticism, Alan Stone had advanced a theory of civil commitment based solely on therapeutic aspirations, returning dangerous conduct to the realm of criminal law. Monahan, however, concluded that it might not be possible or even desirable for clinicians to abandon their commitment to the broader social welfare completely. 'While one would hope that the community protection role of mental health professionals would be minimal relative to their helping functions,' he observed, 'it does not seem to me to be unreasonable of society to demand that a limited "police power" function remain' (16). That being said, he agreed with 'libertarian critics of "preventive justice"' (15) and saw little role for mental health professionals in the setting of prison sentences.

Two complementary strategies allowed Monahan to navigate this complex ethical terrain. First, he moved the debate away from the sorts of predictions that had proven so unreliable in cases where long-incarcerated ‘dangerous’ patients were discharged to the community. Instead, he focused on short-term prediction in urgent or emergent situations, where the context of prediction and the context of validation were identical, the time between prediction and validation was short, and the information available was fresh and current. (These were also the sorts of situations most relevant to the *Tarasoff* ruling.) The consequences of an inaccurate prediction of violence in such a scenario was not trivial—deprivation of liberty for any amount of time was to be taken seriously, though a 72-hour hold differed substantially from indefinite confinement. The consequences of an inaccurate prediction of safety, however, would be catastrophic, and Monahan recognised that organisational pressures would impel providers towards an overestimation of violence risk. Second, Monahan recommended that psychiatrists and psychologists play as limited a role as possible in these decisions. ‘In no sense,’ he observed, ‘do the data on the prediction of violent behavior compel their own policy implications’ (19). As such, he suggested that clinicians limit themselves to providing an estimate of the likelihood of violence, and leave it to judges and legislators—‘the appropriate persons in a democratic society to weigh competing claims among social values’ (19)—to determine what sort of intervention was appropriate on the basis of that probability.

The Clinical Prediction of Violent Behavior proved enormously influential in the emerging field of risk assessment. Monahan’s work, along with that of his sociologist colleague Henry Steadman (who had led much of the research on the *Baxstrom* patients), introduced a style of thinking in which the possibility of future violence was cast in probabilistic terms—a wager about the likelihood of one among many possible outcomes.[23] When he wrote his monograph, Monahan had in mind

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[23] Henry J. Steadman and Joseph P. Morrissey, “The Statistical Prediction of Violent Behavior: Measuring the Costs of a Public Protectionist Versus a Civil Libertarian Model,” *Law and Human Behavior* 5, no. 4 (1981): 263–74; Henry J. Steadman et al., “From Dangerousness to Risk Assessment: Implications for Appropriate Research Strategies,” in *Mental Disorder and Crime*, ed. Sheilagh Hodgins (Thousand Oaks, CA: Sage, 1993), 39–62.

the clinician called upon by the courts to make a formal assessment of an individual's propensity for violence, as evidenced by the illustrative case study and 'model format' that he included in his final chapter.[24] As sociologist Nikolas Rose has noted, however, risk management rapidly became an element of routine psychiatric practice. '[R]isk management is not confined to the question of whether or not a person should be detained in a hospital or prison or to the mentally disordered offender,' Rose observes. '[I]t extends over the everyday life of all patients and all psychiatric professionals.'[25]

Risk Assessment in Context

How are we, as historians, to make sense of these developments? I suggest that at least two larger scale historical trends provide the proper interpretive frames for risk assessment's emergence as an integral part of mental healthcare. The first is the ascent of the risk factor as an object of medical attention during the latter half of the twentieth century. As historians Jeremy Green and Robert Aronowitz have shown, therapeutic interventions in this period increasingly targeted not the signs or symptoms of disease, but rather statistical correlates linked to an elevated likelihood of future adverse events.[26] While demographic and behavioural traits could function as risk factors, the paradigmatic examples were entities like blood pressure and cholesterol—numerically defined and pharmacologically responsive phenomena linked to prognosis in the management of chronic disease. Medical treatment thus became less a matter of relieving suffering than an exercise in contingency management. Trained as physicians in this manner of thinking, psychiatrists proved receptive to the emerging language of risk assessment. And while psychiatry's embrace of

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[24] Author's interview with Monahan.

[25] Nikolas Rose, "Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control," *Psychiatry, Psychology, and the Law* 5, no. 2 (1998): 179. See also Robert Castel, "From Dangerousness to Risk," in *The Foucault Effect: Studies in Governmentality*, eds. Graham Burchell, Colin Gordon, and Peter Miller (Chicago, IL: University of Chicago Press, 1991), 177–95.

[26] Jeremy A. Greene, *Prescribing by Numbers: Drugs and the Definition of Disease* (Baltimore: Johns Hopkins University Press, 2007); Robert Aronowitz, *Risky Medicine: Our Quest to Cure Fear and Uncertainty* (Chicago: University of Chicago Press, 2015). See also William Rothstein, *Public Health and the Risk Factor: A History of an Uneven Medical Revolution* (Rochester, NY: Rochester University Press, 2003).

psychopharmacology in the 1970s and 1980s can certainly be interpreted as an effort to align itself with 'real' medicine, we ought not overlook the ways in which psychiatry also appropriated this new epistemic style for its own ends. Psychiatric disorders thus came to be understood as chronic illnesses whose episodic flares were to be approached with one eye on the management of symptoms and the other on the prevention of catastrophic outcomes involving suicide or violence.

The second, and more general, frame within which we can situate the rise of risk assessment is the turn to neoliberalism as a philosophy of governance in the late twentieth century. Construed narrowly, neoliberalism involved a valorisation of market principles, with concomitant commitments to deregulation and privatisation, and an attack on the policies that undergirded the welfare state. Rationality and individual responsibility were its watchwords. Originally a marginal view among economists and political philosophers, neoliberalism gradually captured large segments of the political right during the 1970s, and achieved a new level of prominence in 1980 with the election of Ronald Reagan.[27] In a society built on market individualism, risks are opportunities for personal advancement and profit. Typically, however, these opportunities are not equally distributed, and while the privileged classes increase their wealth via investments and financial wagers, those who occupy the lower socio-economic strata endure a form of chronic social insecurity resulting from the decline of wage labour, the erosion of union protections and steadily increasing income inequality. As the sociologist Loïc Wacquant has argued, the non-interventionism of neoliberal government is limited largely to the elite, while the lower classes face ongoing and intrusive state involvement in their lives, whether through the criminal justice policies that underpin mass incarceration or the ever more punitive measures incorporated into social welfare provision.[28]

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[27] The literature on neoliberalism is vast, but see e.g. Wendy Brown, *Undoing the Demos: Neoliberalism's Stealth Revolution* (New York: Zone Books, 2015); David Harvey, *A Brief History of Neoliberalism* (New York: Oxford University Press, 2005); Daniel T. Rodgers, "The Uses and Abuses of 'Neoliberalism,'" *Dissent* (Winter 2018), https://www.dissentmagazine.org/article/uses-and-abuses-neoliberalism-debate, accessed 22 January 2018. For another perspective on the intersection of neoliberalism and mental healthcare, see Joel T. Braslow, "The Manufacture of Recovery," *Annual Review of Clinical Psychology* 9, no. 1 (2013): 781–809.

[28] Loïc Wacquant, *Punishing the Poor: The Neoliberal Government of Social Insecurity* (Durham, NC: Duke University Press, 2009).

In this context, risk management emerged as part of the process by which the state was reconfiguring its apparatuses for the management of disruptive individuals. The savings associated with reduced public expenditures on state hospitals rapidly gave way to expanding budgets dedicated to prisons and jails.[29] It would be an exaggeration to characterise the rise of mass incarceration as a direct response to deinstitutionalisation; only a small percentage of those who occupied the crowded state hospitals of the 1950s would have ended up in the prison system half a century later.[30] The shift from the state hospital to the prison as the dominant custodial institution on the social landscape nevertheless underscores a profound shift in ways of thinking about disorderly conduct. Rehabilitation had given way to containment as a guiding strategy. The success of Monahan's monograph lay in its recognition of the mental health professions' role in this new institutional configuration. Monahan himself was wary of psychologists' and psychiatrists' involvement in decisions about sentencing and punishment. By laying out the field so masterfully, however, and by emphasising short-term prediction in emergency situations, Monahan's work was an implicit argument that mental health professionals could make risk assessment a routine element of their work. The courts' decision in *Tarasoff* neutralised any objections that providers might have had about assuming such a role; whether they wanted to or not, psychologists and psychiatrists were now operating as an extension of state power, even when they lacked formal links to the police or courts.

Finally, the emergence of risk assessment in mental healthcare suggests a new perspective on the place of risk during the late stages of modernity. Sociologists Ulrich Beck and Anthony Giddens have suggested that we are living in a 'risk society.'[31] While humans have long faced manifold

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[29] Anne E. Parsons, "Re-institutionalizing America: The Politics of Mental Health and Incarceration, 1945–1985" (Ph.D. dissertation, University of Illinois at Chicago, 2013).

[30] Steven Raphael and Michael A. Stoll, "Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate," *Journal of Legal Studies* 42, no. 1 (2013): 187–222.

[31] Ulrich Beck, *Risk Society: Towards a New Modernity* (London: Sage, 1992); Anthony Giddens, *The Consequences of Modernity* (Stanford University Press, 1990); Anthony Giddens, *Modernity and Self-Identity: Self and Society in the Late Modern Age* (Stanford, CA: Stanford University Press, 1991); Anthony Giddens, "Risk and Responsibility," *Modern Law Review* 62, no. 1 (1999): 1–10. See also Deborah Lupton, *Risk* (2nd ed.) (New York: Routledge, 2013); Pat Caplan, ed., *Risk Revisited* (London: Pluto Press, 2000).

hazards and dangers, industrial progress has freed us from the most pressing forms of material want. In the process, however, we have introduced new forms of man-made risk—environmental collapse, nuclear fallout, manufactured epidemics—that carry even greater potential for the destruction of the species. Our confrontation with these new forms of risk has called into question our relationship with scientific expertise, and has introduced new forms of political organisation and personal identity. Risk and its management in Monahan's work are of a different sort. Here we are discussing the problem of violence, with features that are specific to the social context of the United States in the 1970s and 1980s. Risk assessment is premised on the possibility of a rational and administrative response to interpersonal violence, one that pleads agnosticism on larger social-structural causes. Under neoliberalism, elites have expended considerable energy to insulate themselves from the sort of social insecurity that dominates the lives of the labouring classes. While we know that violence is not distributed equally in society, the threat of violence—particularly at the hands of an individual with a psychiatric disorder—occupies a disproportionate place in the imagination of those least likely to encounter it.[32] The mental health professions have thus assumed a surveillance function, designed to quell the anxieties of those whose health and safety are already privileged. Here we have another, more mundane, element of the risk society, albeit one that returns us to questions of political economy and the distribution of resources, opportunity and power.

Conclusion

At first blush, it is difficult to imagine the prevention of violence—by those with or without a psychiatric disorder—as anything other than a laudable social enterprise. The choices we make about how such a project is implemented, however, carry both ethical and political ramifications. Detention on the basis of predictions about future conduct represents a challenge to our must fundamental ideas of justice.

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[32] It is noteworthy that the rise of risk assessment has proceeded independently of violent crime rates, which climbed throughout the 1970s and 1980s before peaking in the early 1990s. Since then, rates have steadily declined, with no concomitant reduction in the role of risk management in mental healthcare. Uniform Crime Reporting Statistics, https://www.ucrdatatool.gov/, accessed 18 February 2018.

A focus on individual offenders, moreover, distracts us from social structural causes of violence, including lack of investment in education and limited economic opportunity.

Against this backdrop, today's mental health providers remain understandably ambivalent about their role in the management of risk and prevention of violence. While they stand to benefit as a profession from the social authority associated with such a mandate, many object on the basis of their still quite limited ability to make accurate predictions. We might also ask how this constant attention to risk affects the clinical encounter and quality of therapeutic engagement. There is some irony in the fact that modern risk assessment emerged from criticisms of psychiatrists' inability to make reliable predictions, as well as a more general critique of the profession as a form of social control. With the decline of long-term hospitalisation, risk assessment is now part and parcel of everyday practice for most mental health providers. In this sense, psychiatry's social control functions have extended into the community in ways that earlier generations of critics could hardly have imagined, leaving clinicians with less time and energy for the kind of work necessary to help patients achieve a meaningful recovery.

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CHAPTER 9

American Psychiatry in Transition: Reform or Revolution?

Lucas Richert and Matthew DeCloedt

Introduction

In 1969, the American Psychiatric Association (APA) held its annual meeting at the stylish Americana Hotel in sunny Miami, Florida. As participants registered the temperature hovered around 25 °C, but there was tension in the air. Several protestors walked along Miami Beach and loitered outside the hotel, while some licensed and more militant members of the APA were gearing up to make waves during the conference.

The throng of radical psychiatrists at the APA meeting in 1969 exemplified tensions within the mental health field and typified divisions in American society. They argued that the field of mental health needed to transform its training, methodology and service delivery models. It had to throw off neutrality and embrace individual and collective sickness, which some contended were natural byproducts of militarism, alienation, and racism. ‘Therapy means political change’, the radical

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psychiatrists averred at the end of the 1960s, not 'peanut butter', meaning that mental health was intimately tied to social transformation.[1] Only through the latter, they believed, could mental illness be prevented.

Yet, self-described radicals were not always at the forefront of reformist agendas and far from the only health providers to conceive of society as sick. Liberals, as opposed to 'radicals', contributed to the restructuring of mental health care services in the 1950s–1960s by championing social psychiatry and preventive psychiatry.[2] Adherents of both sought to locate the mental patient (and their symptoms) within a broader sociopolitical context. Additionally, both strains of reformers interrogated the health of American society. Given two world wars and a history of slavery and discrimination, it was worthwhile re-evaluating psychiatry's traditional role and thinking more critically about a 'sick society'.[3] Though radicals and reformers—professional and lay—agreed widely on the diagnosis of the problem, their prescriptions were often fundamentally opposed.

Background

The federal government got much more involved in psychiatric reform during the 1960s. The passage of the Community Mental Health Centers (CMHC) Act in 1963 culminated nearly two decades of excitement in the mental health field. The legislation offered federal subsidies for the construction of CMHCs, which were intended to be the foundation of a 'radically new policy'. In addition to CMHCs, Medicaid, Social Security Disability Insurance (SSDI), Supplementary Security Income (SSI) and other resources enabled persons with serious mental disorders to reside in the community. These efforts seemed to work, at least initially, and hospital populations dropped swiftly. Ideas about reform therefore stretched back to the early 1960s and extended beyond labels of 'radical'.

By the 1970s, the US mental health system was comprised of multiple, intersecting institutions: short-term mental hospitals, state and federal

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[1] Jerome Agel, ed., *The Radical Therapist: The Radical Therapist Collective* (New York: Ballantine Books, 1971), viii–xi. Why peanut butter was chosen remains an open question. Successful therapy, however, required social, political and personal change.

[2] Melvin Sabshin, *Changing American Psychiatry: A Personal Perspective* (Washington, DC: American Psychiatric Publishing, 2008), 266.

[3] Sandra L. Bloom, *Creating Sanctuary: Toward the Evolution of Sane Societies* (New York: Routledge, 2013), 114.

long-term institutions, nursing homes, residential care facilities, CMHCs, outpatient departments of general hospitals, community-based programmes, residential institutions and client-run and self-help services, among others. Structures and legislation, in other words, impacted and influenced mental health theory and practice.[4]

But change would not have been possible without the 'rights revolution' of the 1960s and 1970s. The starting point was the drafting in 1970 of 26 such rights by the National Welfare Rights Organization, which led to the American Hospital Association's 1973 'Patient's Bill of Rights'. These were momentous in that they declared that a patient could refuse treatment as well as 'obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis, in terms the patient can be reasonably expected to understand'.[5] More broadly, orthodox thought behind personal well-being, health and psychic security was destabilised in a climate of political insecurity that witnessed 'the rise of libertarian models and conservative politics in the United States'.[6] These social and cultural changes manifested in medicine and the medical marketplace. Citizens formed alliances against the Cancer Establishment and created a cancer counterculture, a pushback against the rich and powerful. Some, who felt they were being bullied by elites, relied on home remedies, others on quackery or folk wisdom, while other groups employed old-fashioned religious faith.[7] Not anti-science per se, these belief systems constituted a reassessment of the purely biomedical model.

The era was uniquely emotive. Fears abounded—of the sexual revolution, an eroding economy, a political system in disarray, of the dénouement of American supremacy. It was a moment of 'testing for Americans', many of whom had come to 'fear that the nation had lost its ability to master its problems'. For many, America had reached a threshold, its people and government on a cliff's edge. Observers 'began to talk of an American climacteric,

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[4] Gerald N. Grob, "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health," *The Milbank Quarterly* 83, no. 3 (2005): 425–56.

[5] Lewis A. Grossman, "The Rise of the Empowered Consumer," *Regulation* 37, no. 4 (Winter 2014–2015): 36.

[6] Dan Carpenter, *Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA* (Princeton, NJ: Princeton University Press, 2010), 730–31. See Philip Jenkins, *Decade of Nightmares: The End of the Sixties and the Making of Eighties America* (New York: Oxford University Press, 2006).

[7] James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1989), ix.

of a sclerotic society irreversibly succumbing to the ravages of age'.[8] Put more bluntly: the US was thought to be going down the drain. Mental health and psychiatry reflected this state of affairs: a mix of hope and scepticism, doggedness and resignation. Some radicals in the psy-sciences preferred to tweak orthodoxies, operate within the system and play with mental health classifications; others wanted a new age entirely and pursued mind-expansion in the treatment room and beyond. Some practitioners—advocating explicitly psychedelic approaches to mental health—quoted William Blake: 'If the doors of perception were cleansed, everything would appear to man as it is, infinite'.[9] Many mental health radicals believed this to be a truism. With the right treatment, no limits constrained the US or its citizens. Mental illness could be prevented, treated and even cured.

The mental health arena also witnessed new entrants, with the rise of patient groups, new therapies tailored for mass consumption and the continuance of psychedelic psychiatry.[10] Patient-consumers could dip their toes into New Age medicine, draw from naturopathy and homeopathy and engage in Eastern-influenced medicine or teachings from sources like the Esalen Institute in California. They might sample alternative mental health therapies, such as Primal Scream Therapy or Transactional Analysis, or find psychic solace in the form of new religious movements. Americans began running for body *and* spirit, struck yoga poses and hit discotheques to allay their emotional anxieties. Individuals, it was posited, could prevent mental health problems from materialising by taking control of their life.

What of practitioners themselves? Various authors had sporadically suggested that mental health professionals were nebbish and cloistered. Robert Coles suggested that psychiatrists 'try to hide behind our couches, hide ourselves from our patients', and prolong 'the very

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[8] Robert M. Collins, *Transforming America: Politics and Culture During the Reagan Years* (New York: Columbia University Press, 2007), 7.

[9] James H. Austin, *Zen-Brain Reflections: Reviewing Recent Developments in Meditation and States of Altered Consciousness* (Cambridge, MA: MIT Press, 2006), 296.

[10] Judi Chamberlin, "The Ex-patients' Movement: Where We've Been and Where We're Going," *Journal of Mind and Behaviour* 11, no. 3 (1990): 323–64; Grossman, "The Rise of the Empowered Consumer"; David Herzberg, "Blockbusters and Controlled Substances: Miltown, Quaalude, and Consumer Demand for Drugs in Postwar America," *Studies in History and Philosophy of Biological and Biomedical Sciences* 42, no. 4 (2011): 415–26; Erika Dyck, *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins University Press, 2008).

isolation often responsible for our patients' troubles'.[11] According to writers in the *American Journal of Orthopsychiatry*, psychiatrists shunned the possibility of 'broad social change' and 'passionate political involvement' for a variety reasons, including professional insulation, a preoccupation with prestige, and an infatuation with methodology.[12] Bruno Bettelheim called psychiatrists 'a rather conservative group', which tended to avoid 'radical analysis' of society's problems, let alone entertain 'radical solutions'.[13] To these critics, psychiatry was at risk of becoming irrelevant if it did not engage with the wider world.

Radical Origins

Raymond Waggoner, the president of the 16,000-member strong APA in 1968, was in touch with the times. 'Change', he asserted, was 'a catchword in American life' and his intention was to oversee 'healthy and wisely determined progress'.[14] He suggested that the APA be more active and take a diversified role in social problems outside of institutional structures. Psychiatrists and mental health organisations, he argued, must agree to take responsibility for social change and social issues. It just so happened that the APA was in the process of modifying its Constitution, with amendments that called for a more 'action-oriented role' for psychiatrists.[15] Instead of 'furthering the study of the nature, treatment, and prevention of mental disorders', the new language indicated efforts 'to improve the treatment, rehabilitation, and care of the mentally ill…and the prevention of psychiatric disabilities'.[16]

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[11] Robert Coles, "Young Psychiatrist Looks at His Profession," *The Atlantic Monthly*, July 1961, 108–11.

[12] Frank Riessman and S.M. Miller, "Social Change Versus the 'Psychiatric World View,'" *American Journal of Orthopsychiatry* 34, no. 1 (1964): 29–38.

[13] Bruno Bettelheim, "Review of Committee on Social Issues, *Psychiatric Aspects of the Prevention of Nuclear War*," *Bulletin of the Atomic Scientists* 21, no. 6 (1965): 55–56.

[14] "Perspectives for the APA Under the New Constitution, 1968," Raymond Waggoner Papers, 1926–1977, Correspondence, Folder 2, Bentley Historical Library, University of Michigan, 2.

[15] Ibid., 15–16.

[16] Ibid., 13. See also "American Psychiatric Association: The Constitution," *American Journal of Psychiatry* 125, no. 3 (1968): 434-a-439.

Overall, he felt, ‘as psychiatrists, we should not be afraid to be social activists’ and that it was ‘time to make concrete plans for psychiatry’s more constructive role in our future society’.[17] This was the ‘establishment’?

Ideologically, radicals in the APA latched onto notions of parochialism, conservatism and neutrality. These concepts were anathema to their ideas regarding prevention and intervention, but they were not alone in their views. By 1969, the American Orthopsychiatric Association, American Academy of Psychoanalysis and the Group for the Advancement of Psychiatry (GAP) had already proven sensitive to pressing social problems. The same was true of the APA and American Psychoanalytic Association (APsaA). Wider public engagement was palpable in the pages of the *American Journal of Psychiatry* (*AJP*) and *Psychiatric News* as well as in the formation of standing committees on such topics as aggression, foreign affairs and poverty. One *AJP* article, by Walter E. Barton, argued that while the landscape in which psychiatry operated was different, not all psychiatrists wished ‘to participate in the social evolution and revolution that are today’s reality’. He cautioned against over-enthusiasm for ‘new fashions’ in psychiatry, even as he remarked that numerous vital issues, including gun violence, needed increased attention.[18] The APsaA, for its part, established a Standing Committee on Social Psychiatry in 1969, something that had not previously interested practicing analysts. ‘Inaction’, it seemed, was no longer an acceptable approach for psychiatry. Instead, the concept of neutrality was increasingly viewed as anachronistic and a possible cause of the field’s decline.[19]

The radicals first coalesced at the APA’s 1968 annual meeting in Boston as ‘Psychiatrists for Action on Racism and the Urban Crisis’. During the May gathering, concern ‘about the grave social conditions in the nation’, the ‘danger of riots’ and ‘the effects of racism and poverty on the social

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[17] Raymond W. Waggoner, “Facing the Challenge of Today,” *Hospital & Community Psychiatry* 20, no. 10 (1969): 298; and Raymond W. Waggoner and Raymond Waggoner Jr., “Psychiatry in the Modern World,” *Current Psychiatric Therapies* 9 (1969): 9.

[18] Walter E. Barton, “Prospects and Perspectives: Implications of Social Change for Psychiatry,” *American Journal of Psychiatry* 125, no. 2 (1968): 147–50.

[19] “The Death of Inaction,” *Psychiatric News*, October 1968. Some excellent examples of psychiatry’s engagement with the wider world include: Bryant Wedge, “Training for a Psychiatry of International Relations,” *American Journal of Psychiatry* 125, no. 6 (1968): 731–36; and Howard P. Rome, “Psychiatry and Foreign Affairs: The Expanding Competence of Psychiatry,” *American Journal of Psychiatry* 125, no. 6 (1968): 725–30.

and emotional well-being of the entire country' resounded.[20] By most accounts, the group was finding its feet and brainstorming about goals. On 15 May, a set of radical psychiatrists supportive of 'social action' in 'urban and racial' relations met to discuss how to improve American communities. Four specific topics were addressed: (I) Working with 'grassroots' groups; (II) Emergency care in violent outbreaks; (III) Changing white racism and (IV) Education and careers. Tackle the social origins of mental illness, they surmised, and it could be prevented. Part laundry list of member activities and part 'how-to' manual for engaging with the critical issues of social movements and racism, the aim of the meeting was to create awareness of the practicalities involved in psychiatric activism.

In San Francisco, for instance, psychiatrists had 'developed a working relationship' with the Black Panther movement. This relationship took the form of offering political support when Black Panther candidates ran for office and delivering medical and psychological services during demonstrations. The practical lesson to be drawn was that mental health providers should 'make oneself available…with these local groups'. To be more successful with grassroots interactions it was 'best to let the initiative come from them as to the role to be played by the medical or psychiatric personnel'. This way, 'maximum autonomy and power' would 'remain in the hands of the community group'.[21]

The first iteration of radical psychiatry thus engaged with the issues of social justice and the social determinants of health, but eschewed direct criticism of the profession and did not adopt a revolutionary ethos. Instead, its philosophy emphasised the need for more 'grass roots education organization' and increased work 'within communities'.[22] While the liberal caucus demanded more APA involvement in the contemporary issues of the day, debate was relatively polite and no one displayed overt hostility. According to a psychiatrist from Boston, who also served as recording secretary for the group in 1968, 'two directions of action were agreed on: a petition at the convention to give immediate expression to the opinions

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[20] Richard Morrill, "Ad Hoc Committee for Social Action," May 15, 1968, MS Coll 641, Box 61, Folder 735, Walter J. Lear Health Activism Collection, Annenberg Rare Book & Manuscript Library, University of Pennsylvania [hereafter WJLHAC] and idem, "Psychiatrists for Action on Racism and the Urban Crisis," May 15, 1968, MS Coll 641, Box 61, Folder 735, WJLHAC.

[21] Morrill, "Ad Hoc Committee for Social Action."

[22] Nathan Hurvitz, "The Status and Tasks of Radical Therapy," *Psychotherapy: Theory, Research, and Practice* 14, no. 1 (1977): 70.

of many attending, and long term activities within the APA itself'.[23] The APA's tepid response to radicalism suggests it was more concerned with keeping things as they were than transforming their policy and preventing mental illness, contrary to what was suggested in its new Constitution.

By 1971, psychotherapist Claude Steiner, having already positioned himself as an organiser and thought leader, offered a breakdown of 'squares' and radicals in mental health. His taxonomy reduced practitioners to distinct subsets and provided a means to understand their disputes, simultaneously obfuscating and explaining radicalism. In Steiner's estimation, Alpha psychiatrists, the largest segment in the profession, were liberal/conservative in their 'political consciousness' *and* in 'practice and methods of psychiatry'. The establishment, in short, that he wished to overthrow. Beta psychiatrists were similarly liberal/conservative in their politics, although these individuals employed radical methods and techniques such as group counselling or the unsanctioned use of drugs. By contrast, Steiner's third category, the Gamma psychiatrist, was radical in politics and traditional in their everyday practice and treatment of patients. Here, anti-psychiatrists R.D. Laing and Thomas Szasz served as examples since they employed 'old, outmoded methods of therapy based on Freudian or neo-Freudian therapy'. The fourth and final type of psychiatrist, a Delta, was radical politically and in psychiatric practice.[24] Unfortunately, intra-radical conflict precluded Steiner's practitioner-types from uniting as a bloc and carrying out a unified program.

PUBLICATION RECORD

Radicals in mental health were provided a forum to discuss their principles and practices in 1970 when Michael Glenn, a United States Air Force psychiatrist in Minot, ND, initiated a Radical Therapist Collective and started *The Radical Therapist* journal. An idea spawned during the cold North Dakota winter, Glenn wanted his publication to be a fiery 'rallying ground' to help develop a therapy 'that serves the people'.[25] However, it was aimed mostly at professionals.

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[23] Ibid.

[24] Claude Steiner, "Radical Psychiatry: Principles," in *The Radical Therapist*, ed. Agel, 1 and 3.

[25] Agel, ed., *The Radical Therapist*, xiii.

Some in the wider radical therapy movement quickly articulated displeasure with the Collective's direction.[26] Many ex-patient groups, deinstitutionalisation advocates, and mental health workers felt it had been 'coopted by those who can publicize themselves'—namely the professional class.[27] The backlash was essentially a byproduct of the 'dominance' of the latter; that is, individuals and cliques who possessed 'the resources and know-how' but did not necessarily represent the totality of the movement.[28] Though '*The Radical Therapist* may not have exhibited all or even the most important segments of opinion held by radical psychiatrists, radical therapists, or radical mental health workers…it constitutes their newspaper of record' because of its wide distribution.[29] The journal served as the primary forum to interpret, reformat, and broadcast anti-psychiatric and radical theories to a larger audience—and because it grew into the movement's chief voice it came to be seen as an establishment organ.

While its 12 issues may not seem momentous, *The Radical Therapist* dealt with breathtakingly complex topics, captured the diversity of radical thought, and provided a snapshot of radical psychiatry's convolution. Its fire did not last long, but it certainly burned brightly—just as Michael Glenn had hoped. Power and the medical model, mental illness prevention and treatment, psychiatric oppression of minority groups and psychiatrist–patient relationships were all addressed. Without deviation, authors framed the goal of traditional psychiatry as 'the maintenance of personal and professional power and prestige, economic well-being, and control over others'.[30] Articles in *The Radical Therapist* also identified the wide-ranging etiological factors that contributed to mental distress in modern America: not just sexism, racism, militarism and the consumer economy, but also American schooling, environmental degradation, bureaucracy and technological growth.[31] Society truly was sick.

The break that began as early as 1969 in Miami was about to lead radicals down very different paths. Deinstitutionalisation was predicated

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[26] Much the same occurred with the Medical Committee for Human Rights in Boston and New York.

[27] Hurvitz, "The Status and Tasks of Radical Therapy," 67.

[28] Ibid.

[29] John A. Talbott, "Radical Psychiatry: An Examination of the Issues," *American Journal of Psychiatry* 131, no. 2 (1974): 121–22.

[30] Ibid.

[31] Ibid.

on improving patients' health through more community interaction, increased reliance on anti-psychotic drugs and, ultimately, was a means to transfer mental health care costs to the federal government. But in a clear allusion to Szaszian theory—specifically, his notion of separating 'psychiatry and the state'—such *RT* articles as 'Radical overview of community psychiatry' and 'Community mental health as a pacification program', argued that the average community mental health centre was a weapon of the establishment; it acted, in short, as a means to pacify angry communities and promote harmony rather than working towards social change.[32] Szasz believed that the state, even outside the confines of large asylums, corrupted psychiatry for its own purposes and warped the profession in ways similar to Nazi Germany or the Soviet Union.[33] Indeed, the statistics on the disproportionate commitment of minorities to American asylums suggested to many that the US was already there: 'In Russia it's a sin to criticize the government, here it's a sin to be poor.'[34] Some, like Jenny Collins of the Alliance for the Liberation of Mental Patients, went further, characterising psychiatric institutions as 'concentration camps'.[35] Hyperbole or not, such views made a split more than likely.

Radicals also squabbled over the issue of consultation and control in community psychiatry. Initially, according to *Madness Is Civilization*, 'community mental health programs represented a great step forward, especially in light of the evidence…that persons from economically depressed backgrounds suffered far higher rates of psychiatric disorders than persons from affluent communities'.[36] Community services, once touted as a positive outgrowth of liberal Great Society thinking and a

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[32] Carl I. Cohen et al., "The Future of Community Psychiatry," *Community Mental Health Journal* 39, no. 5 (2003): 460–62. See Morton O. Wagenfeld and Stanley S. Robin, "Social Activism and Psychiatrists in Community Health Centers," *American Journal of Community Psychology* 6, no 3 (1978): 254; and Rodger Doyle, "Deinstitutionalization," *Scientific American* 287, no. 38 (December 2002): 38.

[33] David J. Rissmiller and Joshua H. Rissmiller, "Evolution of the Antipsychiatry Movement into Mental Health Consumerism," *Psychiatric Services* 57, no. 6 (2006): 864.

[34] Susan Stern, "America's Mental Hospitals: Shock, Drugs, Surgery," *Seven Days*, May 23, 1977, 28, MS 768, Clippings, 1971–1996, Judi Chamberlain Papers, Special Collections and Archives, University of Massachusetts Amherst [hereafter JCP].

[35] Ruth Laughlin, "A Victory for Mental Patients' Rights: Psychiatric 'Treatment,'" 1979, 8, MS 768, Clippings, 1971–1996, JCP.

[36] Michael E. Staub, *Madness Is Civilization: When Diagnosis Was Social, 1948–1980* (Chicago: University of Chicago Press, 2011), 123.

departure from what Erving Goffman deemed oppressive asylums, were now targeted by a segment of radical psychiatrists. Community-based psychiatry did little to prevent mental illness, nor did it empower patients. It was a cosmetic alteration that did not change the fundamentals of how individuals were treated by the establishment. Judi Chamberlin, of the Mental Patients' Liberation Front (MPLF), lamented that the media still stigmatised people with mental health problems living in the community as 'faceless, voiceless phantoms'. In her view, 'community care' was not the entire problem, 'but that greedy businessmen are reaping enormous profits' from providing sub-standard housing to those recently placed in the community.[37] She was right. In 1978, *The New York Times* reported that the state of New Jersey 'doesn't know' what happened to the nearly 40,000 individuals who were 'returned to society' following deinstitutionalisation. Many ended up in 'unlicensed homes' where 'the owners frequently pocket Government funds intended for these outpatients'.[38] The system, even in its more benevolent form, continued to oppress those with mental health issues and profit from their suffering.

The radicals ruptured in 1971. The catalyst was the issue of the legitimacy and intransigence of the psychiatric profession and psy-disciplines. Theoretical differences were vital. Yet, disagreement over support for patient activism, accusations of elitism and a lack of authentic revolutionary action on the part Steiner's Gammas precipitated a split. Some members of Glenn's Collective refuted psychiatry as a valid political activity, repudiating the profession entirely. Psychiatry and sociopolitical change were incompatible. Going back as far as 1967–1968, radicals had questioned the oppressiveness and mystification of mental health therapies. Now, however, the argument was taken further. Proponents of alternative therapy and ex-patients (a.k.a. 'psychiatric survivors') 'eyed each other with suspicion', the latter coming to 'bar professionals from participating in its conferences, newsletters, and self-help centers'.[39] Therapists shot back, suggesting that mental patient liberation groups ignored the broader goals of The Left and were too myopic.

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[37] Judi Chamberlin, "Letters: Frontal Assault," *Voice*, November 28, 1977, 4, MS 768, Clippings, 1971–1996, JCP.

[38] Daniel Lewis and Milton Leebaw, "Where Have All the Patients Gone," *The New York Times*, March 5, 1978.

[39] Alexander Dunst, *Madness in Cold War America* (New York: Routledge, 2016), 54.

A chasm soon separated California's radical therapists from others in the movement, which duly influenced its publications. Acrimony spread, and the Berkeley-based Radical Psychiatry Center, located in the core of psychedelic psychiatry and the emergent New Age mental health environment was singled out as entitled, elitist and a picture of dilettantish radicalism. Steiner had morphed into a *persona non grata* for several reasons. Amid bitterness over the Californians' 'middle-class emphasis on groovy fun and individual solutions', Michael Glenn left the journal he had helped found. The last issue of 1971 printed a critique of the journal's title—talk about radical—and was subsequently renamed *Rough Times*. 'We participate in the world-wide revolutionary force', the newly administered journal held, 'not within the confines of "radicals in the professions"'.[40] Total revolution was the aim, not simply reform.

Steiner, author of the original *Radical Psychiatry Manifesto* in 1970, formed another discrete journal, *Issues in Radical Therapy*.[41] The break-up was not entirely clean, though, and a degree of animus remained. *Rough Times* critiqued the break-away therapists thusly:

> …most of them are too comfortable in their professionally detached attitudes, pseudo-hip life-styles, and removed position from world revolution as well as personal change. We began to see our position in terms of being part of a revolutionary movement. Our goals were more linked to a broad-based socialist movement than to a radical caucus at a professional convention. We began to reassert, with more force and conviction, that RT should be part of a movement to build a revolutionary new world.[42]

The original radicals in mental health were overthrown, but they did not go quietly. Dr. Joy Marcus, who had established herself as a leading radical feminist therapist while in Berkeley, offered a bracing retort. She attacked the change at her former journal as 'depressing, destructive, a rip-off and a cop-out'.[43]

The publications continued to diverge. In successive years, both *Rough Times* and *Issues in Radical Therapy* (*IRT*) printed articles. *IRT*, although a byproduct of discord, regarded itself as constituting part of

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[40] Ibid.

[41] Nick Totton, *Psychotherapy and Politics* (London: Sage, 2000), 28–31.

[42] Jerome Agel, ed., *Rough Times* (New York: Ballantine Books, 1973), i–iii.

[43] Quoted in Totton, *Psychotherapy and Politics*, 28.

the same movement; that said, it conceptualised itself as a practically oriented and prescriptive publication, even as the editors, including Steiner, made clear that any liberal co-optation would be repelled vigorously. *Rough Times*, for its part, eventually altered its name again—this time to *State and Mind*. In doing so, the journal completed a journey into the realm of 'self-help' and 'pop psychology'.[44] It ceased publishing and shut down in 1976. *IRT* offered dense academic articles and came to represent the radical and alternative mental health therapy movement. Its circulation was largely restricted to the Bay Area, completing its run in 1983.

A third publication, *Madness News Network* (*MNN*), further complicated the picture. Also based in the Bay Area, it gave voice to ex-patients and the intersecting threads of mental health liberation groups. *MNN* was founded in 1972 as a newsletter and, while also an outgrowth of political activism and the countercultural strains of the 1960s, it possessed an explicit agenda: tackling the legacy of deinstitutionalisation; addressing the failures of preventative measures, community care and lack of mental health services, as well as offering a safe 'therapeutic space' for the recipients of services in the system. It solicited its readers' views on the goals, strategies and tactics to be employed for 'organizing against psychiatry'.[45] In essence, the editors encouraged readers to 'come out'—to demolish the mystique and fear that often accompanied mental illness.

MNN gradually became a forum for members of New York City's Mental Patients' Liberation Project, Portland's Insane Liberation Front and San Francisco's Network Against Psychiatric Assault, among others. Unlike its counterparts, *Madness News Network* tracked closely with civil rights, gay activism and women's liberation magazines. It aimed to protect the 'rights and dignity of those people labelled crazy'. More than this, and perhaps not surprisingly, *MNN* leant heavily on Thomas Szasz's ideology. Whereas *RT* and *IRT* amalgamated an eclectic group of thinkers, Szasz was pre-eminent at *MNN*. His strident refusal of 'madness' and casting of psychiatry as a modern religion was apparent in the journal from its inception. Indeed, this outlook—stressing indi-

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[44] Dunst, *Madness in Cold War America*, 67.

[45] MNN letter to subscribers, July 29, 1975, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Third, 1975, JCP.

vidualism and denial of mental illness—underpinned much of *MNN*'s political activity.[46] As *MNN*'s readership grew, so too did its influence.

ACTIVATED PATIENTS

Psychiatric survivor movements, according to historian Geoffrey Reaume, failed to achieve the level of support of black civil rights or anti-Vietnam protestors, however, they exerted a tangible influence on mental health policy and terminology.[47] Ex-mental patients' interest groups organised protest demonstrations, circulated petitions, conducted lobbying activities and initiated legal proceedings against psychiatrists and institutions.[48] The Insane Liberation Front (ILF), established in Oregon in June 1970, lasted only six months, but its principal objective—to disassemble the psychiatric institution—was documented in the pages of radical psychiatry articles. A second group, the Mental Patients' Liberation Project (MPLP), was founded in New York City in 1971 by a former ILF member and opposed involuntary treatments, including forced hospitalisation, electroshock, aversive behaviour therapy and psychosurgery.[49] That year, the Mental Patients' Liberation Front (MPLF) was established in Boston. In 1972, San Francisco gave rise to the Network Against Psychiatric Assault (NAPA). Patients were activating and organising all across the country and many ex-patient members of these separate organisations believed that mental illness was a social construction.[50] If they could prevent elites from infiltrating their movement, they could prevent mental illness from proliferating by refusing to cooperate with the propagators of such a harmful idea as 'madness'.

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[46] Thomas Szasz, *Coercion as Cure: A Critical History of Psychiatry* (New Brunswick: Transaction Books, 2010).

[47] Geoffrey Reaume, "Lunatic to Patient to Person: Nomenclature in Psychiatric History and the Influence of Patients' Activism in North America," *International Journal of Law and Psychiatry* 24, no. 4 (2002): 415–17.

[48] Hurvitz, "The Status and Tasks of Radical Therapy," 67.

[49] The name of the MPLF's house publication, "Free Expression," reflected its desire to help ex- and current patients 'fight for our personal liberty'. "Free Expression," MS 768, Clippings, 1971–1996, JCP.

[50] Chamberlin, "The Ex-patients' Movement." See also Lucas Richert, "'Therapy Means Change, Not Peanut Butter': Radical Psychiatry in the United States, 1967–1975," *Social History of Medicine* 27, no. 1 (2014): 104–21.

The ex-patients' movement was far from a static group and adopted various names, including the 'anti-psychiatry', 'mad liberation', 'mental health consumer', and 'psychiatric survivor' movement. The term 'inmate' was employed, as was 'client' and 'consumer', among others. Overall, the movement eschewed distinct leadership, not to mention goals, objectives or formal membership. Empowerment and self-ownership were what mattered, in addition to protecting individuals who had experienced the mental health establishment. These 'non'-members militated against oppression. Actions took the form of forums, protests, press conferences and publications. Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* was published in 1978 to much acclaim. It would later be hailed as the movement's Bible/Koran/Talmud/Vedas/I Ching. Was there a glue for the movement? If anything, the loose collection of organisations spread across the country communicated through *Madness News Network*. As Chamberlin put it: 'In various places across North America there are even single, isolated individuals who are genuine participants in our movement'.[51] Additionally, the first annual Conference on Human Rights and Psychiatric Oppression was held in 1973.

In San Francisco, the Network Against Psychiatric Assault (NAPA) constituted the leading wing of the movement. After its formation in 1974, NAPA targeted the Langley Porter Hospital at the University of California, San Francisco, Herrick Memorial Hospital in Berkeley and the McAuley Neuropsychiatric Institute in St. Mary's Hospital in San Francisco. NAPA opposed the use of electroconvulsive therapy (ECT) in each of these institutions, where it was often undertaken involuntarily or without informed consent. Members invaded locked wards at McAuley to protest involuntary drugging and opposed the startling practice of 'sheeting', wherein uncooperative patients were swaddled—or mummified—as a means of punishment. The Proud Paranoid Theatre Troupe even performed a pantomime 'guerilla version of the sheeting technique'.[52] NAPA targeted specific psychiatrists who frequently used

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[51] Handwritten note, undated, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fifth, 1977, JCP.

[52] Hera Goldman, "Psychiatric Assault," MS 768, Clippings, 1971–1996, JCP.

ECT and proceeded to protest/disrupt their offices and organised a sleep-in at Governor Edmund G. Brown Jr.'s office in Sacramento.[53]

Patient activists, as distinct but interconnecting groups, displayed the squabbling that troubled radical mental health practitioners. The Third Annual Conference for Human Rights and Against Psychiatric Oppression, held in San Francisco in 1975, proved to be a flashpoint. Sick of elitism, tired of being second-class participants in the movement, ex-patients held protests at St. Mary's Hospital, and then gathered at San Francisco's Union Square. They roared, 'Smash the Therapeutic State!' They yelled, 'What do you want? Freedom!' Such emotion was a powerful force in the fight against psychiatry. Describing the conference, one participant stated that it:

> …was just like MPA in a lot of ways—fuzzy, no focus, lots of non-patients…putting down anger as 'not nice.' No, anger is not 'nice,' but it's real, it comes from the gut, and not to be angry at being shit upon is being dead–which is what shrinks and their kind what [sic] us all to become. That's why they lock us up, drug us, cut into our brains with electricity and with knives…because our anger is POWER, and THEY ARE AFRAID OF US. And anyone who is not angry at what they do to usis [sic] as much our enemy as the shrinks themselves.[54]

A full-on fracture occurred on the final day of the conference, which carried over into subsequent years: the ex-patients shut practitioners out. The simple act of slamming the door to outsiders—especially professionals in the psy-sciences, even if they did call themselves radical—was a means to empower ex-patients and embrace their own expertise. It signalled recognition of the divide between service providers and patients and of entrenched inequalities. Indeed, many ex-patients felt they were the true authorities on mental health and derided the hip professionals, an epithet that gained momentum in 1975, the same year *One Flew Over the Cuckoo's Nest* hit theatres. Of the 'hip shrinks [and]

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[53] Patria Joanne Alvelo, "The Politics of Madness: The Women's Liberation Movement in the 1970s" (MA diss., Sarah Lawrence College, 2009); Judi Chamberlin, "Organizing," 4, cited in Lenny Lapon, *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States* (Springfield: Psychiatric Genocide Research Institute, 1986), 170.

[54] Anonymous to Tom, July 19, 1975, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Third, 1975, JCP.

therapists' wanting to attend, they asked: 'Who are they? + What for? At our conference?'[55] Their 'whole idea of "objectivity"' served 'to deemphasize and discredit the passion and anger' of conference participants.[56] Chamberlin, for her part, thought that allowing professionals to attend would give ex-patients the opportunity to vent their frustration: 'The meetings provide a chance for the movement to make clear to these people that ex-inmates are angry, and that we demand the right to speak for ourselves'.[57] But, drawing on Black Power and radical feminism strategies, some ex-patient activists felt separation was often the best way to advance their goals. Breaking away from the mental health system's agents would create a space in which they might achieve their ends. Did it make sense to ally with psychiatrists or psychologists when the aim was a complete abolition of therapeutic intervention? Many thought not.[58] Preventing mental illness meant, in part, preventing professionals diagnosing such illnesses in the first place. The ex-patients secluded themselves the following year.

In 1976, during the next year's conference, ex-patients held meetings apart from the other participants, placing 'Keep Out' signs on the doors. If one had not spent some time in a mental institution, then stay away. Professionals like the Radical Caucus members from Berkeley were consequently put in a position of self-justification, even feeling wounded. One clinical psychologist, Michael D. Galvin, was 'hurt and angry' at being excluded, but wanted to be involved in future projects.[59] Judi Chamberlin replied: 'The presence of someone who presents himself as superior, detached, and professional (as you do) would be most unhelpful'. The conference was for 'former mental patients' who 'want to

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[55] Mabel to Judi Chamberlin, January 4, 1976, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fourth, 1976, JCP.

[56] "Fighting Psychiatric Oppression," MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Third, 1975, JCP.

[57] Judi Chamberlin letter to members, June 8, 1978, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Sixth, 1978, JCP.

[58] See, for example, the Mental Patients' Liberation Project's call for 'no less than [Institutional Psychiatry's] abolition' in Tony Colletti, "The Jailers of the People," MS 768, Clippings, 1971–1996, JCP.

[59] Michael D. Galvin, Ph.D. to Judi Chamberlin, May 6, 1976, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fourth, 1976, JCP.

fight back', not professionals 'with the full intention of being leaders'.[60] Galvin was piqued:

> Your letter was a perfect example of the zeal found in the early phases of liberation movements. It enhances cohesion and the general energy level, but unfortunately seems to go hand in hand with a non-differentiation of targets of anger…You called me 'superior, detached, and professional'…I think I am superior in my clinical abilities…and I am professional in the best sense of the word.[61]

He still believed some good could come of the conference, but did not understand why he should be barred. After all: 'I do subscribe to the R.T. [*The Radical Therapist*] and have long been a member of the ACLU which both do support your cause'.[62] This exchange was a preview of what was to come.

According to Chamberlin, the separation had led to 'noisy confrontations' both within and without the community. She despaired that the conflict had signalled a missed opportunity to confront the 'hip professionals', to discuss 'real alternatives' and challenge 'those who made money off human suffering while presenting themselves as radicals'.[63] But professionals were not totally locked out. NAPA staff indicated that, for their 1977 conference, 'professionals will be allowed to attend…only if they have been specifically endorsed by an ex-inmate/anti-psychiatry group'.[64] Even within these safe spaces there were tensions, with one male participant at the 1977 Boston conference claiming: 'The anti-male sentiment had a strong undercurrent and I wasn't prepared…therefore

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[60] Judi Chamberlin to Michael D. Galvin, Ph.D., May 14, 1976, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fourth, 1976, JCP.

[61] Michael D. Galvin, Ph.D. to Judi Chamberlin, May 19, 1976, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fourth, 1976, JCP.

[62] Ibid.

[63] Lapon, *Mass Murderers in White Coats*, 171.

[64] Letter to Chamberlin, 1977, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fifth, 1977, JCP. This policy was carried over into the 1978 conference. See Letter from The Alliance for the Liberation of Mental Patients to members, April 5, 1978, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Sixth, 1978, JCP.

got overly humiliated'.[65] Chamberlin thought the 'movement is very open, very fluid', but she herself came to be accused of elitism. In self-accusatory language she posited that 'maybe I'm just blind to it'.[66] The limits of these radical partnerships had clearly stretched to the breaking point. It was not only professionals who were not welcome in the movement, but putative leaders and fellow travellers too.

Conclusion

Radicals within the psychiatric establishment acknowledged that they needed to adapt to the modern world, but erstwhile allies and critics in the anti-psychiatry movement would brook no compromise with what they saw as a set of oppressive institutions and practices. Like Peter Finch, playing the radical newscaster Howard Beale in 1976's *Network*, they exhorted their fellow radicals to act. Get out, protest, and prevent injustice. Beale's call could easily have been uttered by activists in the movement: 'I'm a human being, goddammit! My life has value!… I'm as mad as hell and I'm not gonna take this anymore!' And, in acting outside of the traditional avenues of change within the medical establishment, they didn't. Unfortunately, their inability to unite curbed the impact of their agitation.

After analysing *The Radical Therapist* and alternative mental health more broadly, psychiatrist John Talbott suggested that members of the radical Collective were divided into those 'who want to effect change and those who are nihilistic "neo-dadaists"'.[67] To be sure, radicals in the field of mental health had always demonstrated a multifaceted ideology, and the brief history of *The Radical Therapist* not only captured the exertions particular to harmonising such a broad set of ideas, but also tested the limits of the radicals' tolerance for each other. They called each other names. They accused one another of capitulation. Radical psychiatrists, in short, represented the complications and catches inherent in negotiating the mishmash of theories and ideas of Laing, Goffman and Szasz, among others. Contending with and reconciling concepts about the politics of experience, the dangers of asylums, as well as myths of

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[65] Lew Eli Budd to Judi Chamberlin, June 15, 1977, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Fifth, 1977, JCP.

[66] "Frustration in Philadelphia by Judi Chamberlin," undated, 3, MS 768, Series 2, Box 6, Conference on Human Rights and Psychiatric Oppression, Sixth, 1978, JCP.

[67] Talbott, "Radical Psychiatry," 126.

mental illness and state control was not a simple task. Such difficulties were manifest in the pages of *The Radical Therapist*. While certain radicals advocated modifying how community psychiatry was conducted, others suggested that this practice was another mode of state control.

Difficulties in streamlining radical theory were also present in radicals' association with patient survivors. The belief in professional boundaries between physician and patient prevented some psy-professionals, even though they considered themselves radical, from coming together. By contrast, others felt those boundaries were artificial, injurious to the patient and required total demolition.[68] Likewise, involuntary hospitalisation, psychoactive drugs, electroshock, behaviour modification and psychosurgery all served to split radical psychiatrists. In the end, radical psychiatry, even as it recast older theories, coalesced and splintered, was 'ideologically all over the map'.[69] From its inception in 1968, radicalism proved to be an intricate and incompatible mixture of ideas and a straightforward anti-psychiatry classification does not adequately encapsulate the complexity of the movement. It sought social transformation, but it also unwittingly contributed to the rise of popular self-help psychology, blended with New Age ideas regarding the mind and body and changed the relationship between citizen and government. Prevention thus became the remit of the individual.

The eventual buckling of the radical movement was caused by various weights and tensions. A number of radicals advocated wholesale commitment to social revolution in the belief there would be no mental illness in utopia. Others wanted to focus on reforming psychiatry itself, rather than sidelining it in favour of political action. Several radical articles, which proposed a Bill of Rights, agreed with the Insane Liberation Front and called for the comprehensive dismantling of the capitalist system, mental institutions, mental commitments and the practice of psychiatry more broadly. By contrast, other articles in *The Radical Therapist* concurred with the moderate MPLF, led by Chamberlin, advocating reform of mental health practices.[70] While there may have been some agreement between professional psychiatrists, psychologists and patients

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[68] Hurvitz, "The Status and Tasks of Radical Therapy," 68.

[69] Staub, *Madness Is Civilization*, 5.

[70] Quoted in Talbott, "Radical Psychiatry," 124–25. See "Insane Liberation Front," in *The Radical Therapist*, ed. Agel, 2 and 15; "Mental Patients' Liberation Front: Statement," in ibid., 2 and 24.

groups, there was little uniformity regarding the appropriateness of their association. Some believed that former mental patients and professional therapists should collaborate directly while others felt that they could ‘work together but not in the same organization’. Similarly, most radicals considered ‘involuntary hospitalization, psychoactive drugs, electroshock, behavior modification, and psychosurgery as harmful’, yet others regarded such treatments ‘as useful in specific instances’.[71]

For some radical psychiatrists it was necessary to dismantle the domineering psychiatric profession–a monolithic, conservative structure—and at the same time impose constraints on the imperialistic expansion of psychiatry; for others, reform was the ultimate goal. The radical psychiatry ideology, in short, embodied both positive and reformist sentiments and anarchistic and nihilistic viewpoints. In Mark Kurlansky’s interpretation of radicalism in 1968 and beyond, ‘ideologies were seldom clear, and there was widespread agreement on very few issues’.[72] Radicals in mental health were similarly divided. Though they agreed on the need to transform psychiatry, few saw eye to eye on what that meant and how it was to be done. Psychiatrists wanted to prevent society from succumbing to its sickness, while those in the anti-psychiatry movement sought to prevent mental illness from increasing its capacity for oppression.

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[71] Hurvitz, “The Status and Tasks of Radical Therapy,” 68.

[72] Mark Kurlansky, *1968: The Year That Rocked the World* (New York: Ballantine, 2004), xvii.

CHAPTER 10

Designing for Mental Health: Psychiatry, Psychology and the Architectural Study Project

Edmund Ramsden

Introduction

In historical reflections on the architecture of the mental hospital, there is a familiar narrative arc.[1] This runs from an optimistic era of moral treatment in the eighteenth and nineteenth centuries which informed the designs of those such as Thomas Kirkbride that the hospital should be light, spacious and connected to nature, to one of intense pessimism in the twentieth, with damning exposés and critical ethnographies of the mental hospital that used personal accounts and participant observation

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[1] See, for example, Lawrence A. Osborn, “From Beauty to Despair: The Rise and Fall of the American State Mental Hospital,” *Psychiatric Quarterly* 80 (2009): 219–31.

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D. Kritsotaki et al. (eds.), *Preventing Mental Illness*,
Mental Health in Historical Perspective,
https://doi.org/10.1007/978-3-319-98699-9_10

techniques to dramatic and disturbing effect.[2] In Albert Deutsch's *The Shame of the States*, the reader is introduced to inhuman practices and conditions, and in Erving Goffman's *Asylums* to the idea of the 'total institution' in which 'a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered rounds of life'.[3] The mental hospital therefore becomes an intensely problematic space due, in part, to its physical features such as its geographical isolation from the world, designs for confinement and surveillance, depressing wards and crowded dormitories. It is also seen as a site of perpetual conflict between disciplines and communities, such as psychiatrists, psychoanalysts and social and behavioural scientists, the latter gaining their institutional strength and legitimacy from the university, rather than the mental hospital which was increasingly questioned as a locus of research and care.[4] Together with the emergence of new drugs and therapies, this criticism contributed to the opening-up of psychiatric services from the 1950s with the emergence of community care legislation, the growth of psychiatric units in general hospitals and the establishment of new buildings such as Community Mental Health Centres to better integrate different therapies and communities, rehabilitate patients and prevent mental illness.

This chapter will take a different tack, and, rather than seeing the mental hospital as cut off, isolated and left behind, will examine it as a physical space that served as a crucial site for cross-disciplinary communication and collaboration in the twentieth century. The architectural historian Daniel Abramson has explored how the 'obsolescence' of urban buildings generated innovative solutions through designs that emphasised flexibility, choice and freedom, and so too in the case of the mental hospital where architects and psychiatrists came together to provide creative

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[2] On Kirkbride, see Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007). See also Leslie Topp, James E. Moran, and Jonathan Andrews, eds., *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (New York: Routledge, 2007).

[3] Albert Deutsch, *The Shame of the States* (New York: Harcourt, 1948), Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday, 1961), xiii.

[4] See Andrew Scull, "Psychiatry and the Social Sciences, 1940–2009," *History of Political Economy* 42 (2010): 25–52.

solutions for a system under severe pressure.[5] We will be focusing on the short history of a collaborative project between the American Psychiatric Association (APA) and the American Institute of Architects (AIA), and the longer term influence of some of the individuals, principles and practices involved. The Architectural Study Project (ASP) began in 1953 and reflected a growing concern with the state of mental hospital facilities. Psychiatrists and architects turned their attention to various aspects of the hospital environment, such as light, colour and the creation of spaces for privacy and social contact, in ways that would go on to influence theories, methods and designs developed and applied far beyond the walls of the institution. This chapter explores the role of the mental hospital as a 'hybrid' place and an 'experiment' of nature and society that combined elements of laboratory and field.[6] As Robert Kohler argues, the adaptation of laboratory instruments and techniques to the field helped to create a 'distinctive border culture' or 'zone' which proved a richly fertile ground for modern biology.[7] Critical to its success was the reinvention of the field as a place where experiments were possible. Mary Morgan has focused on the significance of 'Nature's or Society's experiments' in which events, situations or places provide elements of isolation and control that give them value as 'rich sites for scientists to research'.[8] Here, we will see how the mental hospital served as such a site for an emerging interdisciplinary field of environmental psychology, allowing for new methods for mapping behaviour and measuring emotional reactions and the development of concepts such as personal space to analyse the relationship between human beings and their physical environments. The work that resulted from the study of the mental hospital would play a critical role in the study, planning and designing of the wider territories of the city to prevent mental illness and promote mental health and psychosocial well-being in the United States in a period of urban crisis.

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[5] Daniel M. Abramson, *Obsolescence: An Architectural History* (Chicago: Chicago University Press, 2016).

[6] On the value of uniting these two elements, see Thomas F. Gieryn, "City as Truth-Spot: Laboratories and Field-Sites in Urban Studies," *Social Studies of Science* 36 (2006): 5–38 (7).

[7] Robert E. Kohler, *Landscapes and Labscapes: Exploring the Lab-Field Border in Biology* (Chicago: University of Chicago Press, 2002), 134.

[8] Mary Morgan, "Nature's Experiments and Natural Experiments in the Social Sciences," *Philosophy of the Social Sciences* 43 (2013): 341–57 (354).

The Architectural Study Project

In a paper read before the American Hospital Association (AHA), Daniel Blain, Medical Director of the APA, declared 1953 to have been an 'epochal year' for mental health. Events had demonstrated 'that we have come to the end of one era and are at the beginning of another'.[9] Not to be overlooked among the congressional hearings and the 'outstanding' treatments by the World Health Organization (WHO) and National Institute of Mental Health (NIMH), was the APA's comprehensive report on manpower and the move to standardise training. With these contributions, the mental health field was moving from 'vague and subjective planning efforts to a more scientific quantitative approach'. It was also embracing a wider range of preventative measures and treatments that recognised the relevance of psychological, socio-economic and political conditions. Blain interpreted this reorientation through scientific planning as contributing to a shift from the 'mere adding of hospitals' to the 'provision for multitudinous other services'.[10] It had not come soon enough in North America, with its 'enormous' hospital system of which 714,000 beds of the total 1.5 million were filled by mental patients, and another 300,000 were required. It was expensive and dangerously short staffed, with recruitment crippled by the damning revelations of 'inhuman conditions' in large state mental hospitals.[11] In this regard, Blain observed that 1953 was also the year that the APA had secured a large grant from the Rockefeller Foundation and the Division Fund of Chicago for a 'first project on design, construction and equipment of mental hospitals'.[12] The ASP reflected both a determination to fix the ailing hospital system and a growing interest in designing and building for new philosophies of prevention and treatment that moved away from long-term custodial care.

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[9] Daniel Blain, "Mental Health Program Planning," read at the Institute on Hospital Planning, American Hospital Association (AHA), DC, February 16, 1954, Archives of the American Psychiatric Association, Architecture Study Project (hereafter ASP Papers), Folder 122. See also Daniel Blain and Robert L. Robinson, "A New Emphasis in Mental Health Planning," *American Journal of Psychiatry* 110 (1954): 702–4.

[10] Blain, "Mental Health Program Planning."

[11] Memorandum: Mental Health, July 1955, Council of State Governments, Chicago, ASP Papers, Folder 106.

[12] Blain, "Mental Health Program Planning." They received $140,000 from the Rockefeller Foundation and 15,000 from the Division Fund.

The ASP grew out of a conference in April 1952 organised by the APA to develop solutions for a system suffering ‘extreme overcrowding’ in buildings ‘obsolete, deteriorated, and sometimes condemned’.[13] While new treatment strategies might reduce the hospital population of the future, they still had a ‘vast backlog’ of patients who were so damaged that they required long-term custodial care in buildings that needed to be rehabilitated or replaced. Many buildings, even new projects, failed to properly consider patient and staff needs, and, as a consequence, lacked the ‘optimism’ and ‘atmosphere of peace and comfort’ of a truly ‘therapeutic milieu’. Environment was of critical importance because mental patients were unusually sensitive, and this was compounded by the fact that their stay would last for months, even years; it could not afford to be ‘dingy, forbidding or bleak’. While the two days of discussion did not contribute any new design solutions, it did confirm an awareness of the need for the exchange of information between those who designed and constructed the buildings and those who worked in them. It was decided that the fundamental cause of the failure of hospitals was the ‘lack of mutual understanding between doctors and designers of each other’s needs and problems’.[14]

To realise what the architect Isadore Rosenfield described as the ‘humanization of mental hospitals’, they needed some form of central agency where hospital planners, administrators, architects, engineers and psychiatrists could contribute ideas and access the latest information, criteria and standards.[15] Architects expressed their frustration at not having fully explained to them the function of a ward or treatment and on the absence of a comprehensive source of reliable answers to a wide range of questions. Therefore they were hindered in their attempts to realise functional design, the precepts of which are central to modern architecture. Psychiatrists, in turn, were disappointed by how poorly medical needs were met by designers.[16] Seeking to solicit funds to launch such a project, the conference proceedings were published and circulated in pamphlet form as ‘Design for Therapy’. Included was a proposal for an

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[13] Daniel Blain, “Heart of the Matter,” in *Design for Therapy: An Investigation into The Possibilities of Collaboration Between Psychiatrists and Architects in Developing Basic Information for Mental Hospital Design, Construction and Equipment*, Conference in Washington, DC, April 6–7, 1952, p. 5, APA, ASP Papers, Folder 90.

[14] Blain, “Heart of the Matter,” 6.

[15] Blain quoting Rosenfield in “Heart of the Matter”, p. 7.

[16] See “Notes from Talk by Dr. Paul Haun,” 1/10/55, Consultants’ Meeting, ASP Papers, Folder 104.

organisation to collect, analyse and disseminate the 'best information' on design, construction and equipment, and an introduction written by Blain which declared: 'With close collaboration between architecture and psychiatry once established, mental hospital design for modern treatment can become a reality. Buildings yet to be blueprinted will help instead of hinder the task of those who will work in them for the ultimate recovery or easement of the patient.'[17]

The ASP was directed by the APA with a strong input from the AIA who helped to provide a series of architectural consultants. Alston Guttersen, an architect with experience in hospital design with the US Public Health Service, was employed full time as the Project's Assistant Director. A wide range of experts were called upon to give evidence on various technical elements of design and equipment, such as colour and furnishings, to help humanise hospital architecture by making it 'more home-like'.[18] Through correspondence, conferences and hospital visits, the ASP began to collect vast amounts of material relating to elements of design, such as blueprints for new buildings, wards or recreation facilities or information on materials for walls, windows or doors. This was then organised and shared as the ASP offices became a clearing house of information, inundated with requests from administrators, planners and designers seeking to build or refurbish. They established a consultancy service, organising expert interventions on request (for a small fee) and served clients across North America. They also put local architects and psychiatrists in contact with one another, establishing joint teams to aid with the collection of data regarding good and bad design practices. To help share information and generate publicity, examples of good design—consisting of descriptions, sketches and blueprints—were published in a new architectural section in the monthly magazine *Mental Hospitals*, which some 700 hospitals subscribed to.[19] The object, as psychiatrist and ASP Director Charles Goshen, declared, was to provide 'little notes on various innovations' and 'ingenious little ideas from various people'.[20]

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[17] Blain, "Heart of the Matter", 8.

[18] "Mental Hospital Architecture," n.a., n.d., ASP Papers, Folder 91.

[19] "Proposed Hospital Construction and Equipment Project, to be administered by APA Mental Hospital Service," ASP Papers, Folder 92. *Mental Hospitals* was published by the APA's Mental Hospital Service, which served as a clearing house for technical information.

[20] Charles Goshen, "Summary of Year's Progress and Projects Now Underway in the Architecture Study Project, to APA Council," November 1957, ASP Papers, Folder 118.

ASP members saw their role as working to dispel the fog of 'ignorance and prejudice' surrounding mental hospitals in the minds of architects who, through design, ended up making 'many of the major decisions on the subject'.[21] Patient sensitivities were described, and design implications suggested, such as countering the common tendency to withdraw by means of environmental innovations that could 'draw and hold human interest'.[22] Colour, long associated with emotion, was explored as a means of making the hospital atmosphere seem softer, less institutional and, where needed, as an 'attention-getting' measure.[23] But ASP members were also concerned to influence the field of psychiatry, to encourage it to move beyond the mental hospital as the site for psychiatric care. This was an issue that emerged early in the debates regarding the Project's direction, and with subsequent changes in leadership, it became increasingly central. With the final two directors, Lucy Ozarin and Charles Goshen, in 1956 and 1957 respectively, a greater proportion of Project work became oriented towards alternatives to large state mental hospitals such as the day hospital, clinics, community centres and psychiatric services or units in general hospitals.[24] In their correspondence, Goshen and Ozarin questioned building for the 'sole purpose of housing more patients' and argued that future needs for rehabilitation would be met by smaller and more flexible installations, providing 'more personal and… a better type of psychiatric care'.[25]

The travels of Guttersen in Europe, in part funded by the WHO, helped to popularise the opening-up of psychiatric units to the community. His accounts of visits to facilities abroad were published in *Mental Hospitals*, complete with detailed descriptions, sketches and

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[21] "Space—The Essence of Mental Hospital Design," n.a., n.d., ASP Papers, Folder 91.

[22] "Mental Hospital Design—Environmental Therapy," n.a., n.d., ASP Papers, Folder 91.

[23] Charles Goshen, "Guidelines for the Development of Psychiatric Services in General Hospitals," n.d., ASP Papers, Folder 90.

[24] Both had worked in some of the most innovative sites of psychiatric work, Charles Goshen as Executive Director of the first private day hospital, the Robbins Institute in New York, and Lucy Ozarin as Chief of Hospital Psychiatry in the Veteran's Administration. There were numerous directors over the years which did not help the Project's coherence, and prior to Ozarin and Goshen, John L. Smalldon served as director with the beginning of the Project on September 8, 1953, and he was replaced by Charles K. Bush in May 1954. "Report to the Rockefeller Foundation of the Activities of the Mental Hospital Architectural Study Project, from June 1, 1954 to May 31, 1955," ASP Papers, Folder 105.

[25] Goshen to R. E. Peek, August 28, 1958, from Goshen, ASP Papers, Folder 88; Ozarin to Samuel Whitman June 25, 1956, ASP Papers, Folder 119.

photographs, and made the point that the US in particular was falling behind. New advances in treatment, most notably the new range of tranquilising drugs, allowed and indeed required new kinds of psychiatric spaces. For example, Goshen observed that the 'elaborate facilities' needed for insulin and electric shock therapies were no longer necessary, and that the 'old-fashioned hydro-therapy units have become storage rooms'.[26] The ASP was also building on the conclusions of the Joint Commission on Mental Illness and Health which, by bringing a wide range of health and service organisations together from 1955, had sought 'solutions outside of the traditional framework of the mental hospital'.[27] Goshen went so far as to describe the mental hospital as having a 'built-in obsolescence' due to the fact that all but the most difficult patients sought alternatives to the closed institution.[28] In the place of custodial isolation, the ASP promoted two alternative psychiatric spaces, the day hospital and psychiatric services in general hospitals. The latter was a means of better integrating psychiatry with general medicine, thereby connecting more successfully with the public and taking advantage of the federal funds spent on hospital construction following the Hill-Burton Act of 1946, of which psychiatric services had received little. The day hospital provided intensive treatment while allowing the patient to retain and rebuild important connections to family and community. The psychiatrist Bernard Robbins argued that with the range of activities on offer and an atmosphere that was more like a 'school, club or workshop', they could make a 'clean break with the undesirable aspects of the tradition surrounding the usual psychiatric hospital'.[29] These new kinds of environments would, in turn, drive innovation in psychiatry as, by bringing together diverse groups of mental health researchers and professionals

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[26] Charles Goshen, "A Re-appraisal of the Architectural Study Project," 7/15/57, ASP Papers, Folder 104.

[27] Arthur Noyes, President of the APA, to Edwin Crosby, Director of the AHA, February 22, 1955, ASP Papers, Folder 83.

[28] Goshen, New Concepts of Psychiatric Care with Special Reference to the Day Hospital: A Summary of the Proceedings of the First National Day Hospital Conference held in Washington D.C., March 1952, presented at the Annual Convention of the APA, May 13, 1958, ASP Papers, Folder 76.

[29] Bernard S. Robbins, "The Theoretical Rationale for the Day Hospital," in *Proceedings of the 1958 Day Hospital Conference, A Mental Hospital Design Clinic Conducted by The Architecture Study Project and The General Practitioner Project of the APA*, Washington, DC, March 28–29, pp. 6–7, 1958, ASP Papers, Folder 76.

around psychiatric places, rather than theories, it would be possible to build common therapeutic practices.[30]

However, there were tensions between ASP members. Some wanted a much broader focus on mental health programming and community services from child guidance centres to clinics for the treatment of addiction. Others wanted to continue restricting the attention of the ASP to hospitals, private and public. In meetings, they spoke of the need for a 'manual' for hospital design, with Blain hoping for 'a sort of textbook on mental hospital architecture for the use of the people doing the building'.[31] But Guttersen was noticing a growing 'preference for the first activity on the part of some of the Consultants'.[32] The architect Moreland Griffith Smith was forthright, declaring that as 'pressing' as the problems of institutional facilities may have been, the ASP was in an 'ideal position to do more'; the promotion of psychiatric facilities in general hospitals could, he suggested, be the Project's 'finest contribution'.[33] The ASP was being pulled in two directions, one towards improving conditions for the huge majority of psychiatric patients still being treated in large mental hospitals, and the other, away from the total institution in an effort to keep pace with a field that was changing rapidly. It was proving difficult to reconcile these approaches and establish coherence. The psychiatrist Addison Duval expressed his concern early in the Project, that with 'such a diversity of opinion… the Study will come up with nothing'.[34] With this continuous broadening of the Project's base, the end goal of the ASP was also shifting. The idea of a 'manual' or 'textbook' of standards and plans was being displaced by a more flexible and universal series of 'principles' of design that could

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[30] Charles Goshen, "Day Hospitals: Physical Facilities and Equipment," presented at the First Day Hospital Conference, Washington, DC, March 1958, ASP Papers, Folder 76.

[31] "Minutes—Meeting of Consultants' Committee," ASP, April 5, 1954, ASP Papers, Folder 120.

[32] Alston Guttersen, "Review of Designated Activities for the Architectural Study Project," ASP Papers, Folder 93.

[33] Moreland Griffith Smith, "RE: Proposed National Plan for Mental Health Facilities," ASP Papers, Folder 93.

[34] "Minutes—Meeting of Consultants' Committee," ASP, March 1, 1954, ASP Papers, Folder 120. Duval was an important and influential member of the ASP as he served as Chair of the Committee on Standards for Psychiatric Hospitals and Clinics of the APA, which he combined with his role at St Elizabeth's Hospital in Washington, DC, where Goffman had carried out his studies.

travel across these increasingly varied sites of psychiatric treatment and satisfy concerns with both hospital improvement and more diverse psychiatric services. As Goshen argued, 'There is no single set of model blueprints which could be reasonably recommended as a guide to design any psychiatric unit.'[35] To generate these principles, as well as plan more effectively for the future, the ASP needed to conduct its own studies rather than merely rely upon information and opinion offered by others.

The Mental Hospital as an Investigative Space

When Goshen assumed the directorship of the ASP in 1957, he described the dissipation of early optimism that 'new and progressive ideas, as well as standards, for mental hospitals might be developed'. As psychiatric care had been changing so quickly, the 'Project never really came up with anything of value'.[36] Goshen was seeking ways to make the project 'perform'. The ASP would move beyond its early attempts to match building types with demographics or therapies and better appreciate the environment from an architectural perspective, as one architect demanded: 'We do not want standards, we want principles and philosophy'.[37] This meant understanding how space was experienced and used in the day-to-day life of a hospital, space being, it was argued, 'the essence of mental hospital design'.[38] Here, Goshen was building on the direction established by his predecessor, Lucy Ozarin, who saw the development of 'principles' of design as dependent upon a programme of investigation.[39] Research was not new to the ASP and in late 1954, they had begun the laborious process of sifting through thousands of hospital admissions to secure 'basic data' to aid planning in accordance with

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[35] Goshen, "Guidelines for the Development of Psychiatric Services", p. 11.

[36] Goshen to Vincent Kling, July 24, 1957, ASP Papers, Folder 88. Goshen wanted to involve Kling as a consultant as he believed that, despite Alston Guttersen's contribution, the project lacked 'any real architectural orientation'.

[37] John R. Magney, "Minutes—Advisory Committee Meeting," December 14, 1956, ASP Papers, Folder 120.

[38] "Space—The Essence of Mental Hospital Design."

[39] "Proposal for a Program of Investigation and Evaluation of Psychiatric Facilities Leading to the Derivation of Principles of General Architectural Design and Equipment," November 30, 1956, ASP Papers, Folder 120. This shift towards investigation was also driven by the failure of the psychiatrist and architect teams, few returning the prepared questionnaire.

changing patient needs.[40] But as the ASP adopted broad survey methods to mirror its widening focus, some were driven to question: 'is this an architectural approach?'[41] Ozarin's work was more directly tied to architectural concerns with the use and function of space. Her studies sought to improve design through the application of observational techniques used in the social, biological and behavioural sciences, thereby complementing the quantitative approaches applied for the benefits of planning.

Aided by a clinical psychologist, Abdul Tuma, Ozarin's studies consisted of 'direct observation' of patient and staff movements and activities.[42] In a study of patients in seven psychiatric wards in five general hospitals, movement was recorded for a total of 18 hours over several days. Every 15 minutes in 3-hour blocks of time, the patients were checked to see where they were and what they were doing. Observation generated specific information on space requirements and allowed Ozarin to make a series of recommendations: few patients needed to be housed in secure wards; open wards which allowed patients to use the kitchen generated an 'active social center'; lots of small semi-private spaces were better for activities than large day rooms; the option of single bedrooms was critical for patients in need of privacy; and spaces for occupational therapy and recreation were essential.[43] Following another study, it seemed apparent that nurses stations 'do not suit the purposes they presently serve'. Physical barriers, such as a pane of glass, isolated staff from patients.[44] More generally, Ozarin used the evidence to criticise atmospheres that were 'rigid', 'bare' and 'typically institutional',

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[40] This survey originally encompassed 10,000 case records of patients admitted to six state hospitals and two outpatient psychiatric clinics in the calendar year of 1953 and was then extended to include other facilities in accordance with the broadening focus of the ASP. The widening survey approach did not help their case when they requested an extension to their grant, and the source of funding shifted from the Rockefeller Foundation to the NIMH.

[41] Duval in Meeting, AHA & ASP, June 30, 1954, ASP Papers, Folder 105.

[42] "Progress Report, ASP, APA, Study of Intensive Treatment Facilities for Psychiatric Patients, USPHS Grant W-5, 1956," ASP Papers, Folder 105. Abdul Tuma was employed by the ASP having been recommended by the VA. Ozarin to Abdul Tuma, June 7, 1956, ASP Papers, Folder 111.

[43] Lucy Ozarin, "Patterns of Patient Movement in General Hospital Psychiatric Wards," ASP Papers, Folder 91. Later published in *American Journal of Psychiatry* 114 (1958): 977–85.

[44] "Addendum to Progress Report", Study of Intensive Treatment Facilities for Psychiatric Patients, USPHS Grant W-5, 1956, ASP Papers, Folder 121 and Lucy Ozarin, "Functions of Nursing Stations on Psychiatric Services in General Hospitals," ASP Papers, Folder 90.

and celebrate open, busy, active, comfortable and colourful wards with reduced security measures and increased patient privileges.[45]

In designing her studies, Ozarin drew from a variety of sources. She credited the so-called 'Boston experiment' for having re-established a philosophy of 'social treatment'.[46] At the Boston Psychopathic Hospital, psychiatrists, anthropologists and social scientists had come together to explore how the environment could be used more therapeutically. To this, the ASP could contribute the important dimension of improved physical design.[47] She drew from the sociological study of a private mental hospital by Alfred Stanton and Morris Schwartz who, in their volume *The Mental Hospital* of 1954, privileged highly 'acculturated' conditions over the cold, charmless and 'spartan' environments so common to institutions, as critical to patient recovery.[48] By 1957 Stanton was writing to Ozarin to request help with an 'architectural problem' at one of the Harvard Medical School's psychiatric hospitals.[49] Ozarin also drew from some less obvious sources, such as the work of Heini Hediger, zoo director and author of several influential books on animal behaviour in captivity. As an ethologist, Hediger argued that it was essential to design artificial environments in accordance with the biologically determined behaviour of a species. To do otherwise resulted in pathologies comparable to those of human beings in the total institution. As Ozarin surmised, the health and well-being of animals were determined by the 'quality and quantity of space in which they live'.[50]

Ozarin had learnt of Hediger's work from a psychiatrist, Humphry Osmond, whose ideas and methods would prove increasingly central to the work of the ASP. As director of Weyburn Hospital, Saskatchewan, Osmond had been seeking design solutions for a hospital described by his research associate as 'cavernous, poorly lit, with long corridors,

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[45] Ozarin, "Patterns of patient movement." See also, A. H. Tuma and Lucy B. Ozarin, "Patient 'Privileges' in Mental Hospitals," *American Journal of Psychiatry* 114 (1958): 1104–10.

[46] Lucy Ozarin, "New Horizons in Psychiatry," ASP Papers, Folder 91.

[47] The physical environment was the thinnest section of the resulting volume—Milton Greenblatt, Richard H. York, and Esther L. Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals* (New York: Russell Sage Foundation, 1955).

[48] Ozarin, "New Horizons."

[49] Alfred Stanton to Ozarin February 13, 1957, ASP Papers, Folder 113.

[50] Ozarin, "Patterns of Patient Movement."

institutional colors, inadequate ventilation, and little soundproofing'.[51] The flaws of Weyburn were all too common, a 'testimony to the failure in communication which has existed between architect and psychiatrist for much of the last century'.[52] Osmond worked with Robert Sommer, a psychologist, and architect, Kiyoshi Izumi, to design an alternative therapeutic space. But they were immediately struck with the lack of information available, Sommer later complaining: 'More was known about the design of zoo cages and chicken coops than about the design of hospital wards.'[53] Zoo animals were expensive, he quipped, and often the subject of greater sentiment than the mentally ill, and 'this is sufficient reason to undertake research into conditions necessary for their survival'.[54] And so, it was Hediger's insights that helped them to develop a methodological and analytical framework for understanding the relationship between people and the physical environment. The most important requirements for the individual were spatial. Patients needed spaces in which they could interact with others, but on their own terms. They needed their own territory and privacy. Osmond argued that Hediger had 'shown that for many wild animals incarcerated in zoos, the presence or absence of this nest or den makes the difference between the survival or death of the creature. He has also shown that the size of this place is much less important than that it should be *functionally rather than structurally* equivalent to the conditions found in nature'.[55]

Through their own observational studies, the Saskatchewan team argued that the quality of physical space was more important than its quantity; for psychotic people, smaller rooms, even with as little as 50 square feet of floor space, were better than overly spacious, often cavernous, dormitories, whose scale was likely to confuse and overwhelm. It was critical to avoid ambiguous, muddled and complicated designs and ensure that spaces were manageable and clearly defined to avoid making demands on the patient's impaired perceptual apparatus. Social

[51] Robert Sommer, "Studies in Personal Space – This Week's Citation Classic," *Current Contents* 24 (1983): 14.

[52] Humphry Osmond, "Function as the Basis of Psychiatric Ward Design," *Mental Hospitals* 8 (1957), 23–29 (23).

[53] Sommer, "Studies in Personal Space."

[54] Robert Sommer, *Personal Space: The Behavioral Basis of Design* (Englewood Cliffs, NJ: Prentice-Hall, 1969), 12.

[55] Osmond, "Function as the Basis of Psychiatric Ward Design", 25–26.

interaction also needed to be controlled to reduce the possibility of panic and withdrawal, while maintaining healthy and suitable social relationships. Enlarged spaces meant increased frequency of unwanted social contact due to high population numbers; 'unpleasant even for the healthy people', such overconcentration could 'so damage the mentally ill that they lose all hope of recovery'. The large corridors that dominated hospitals were a particular problem as they were 'admirably suited for keeping people on the move, but ill-suited for developing interpersonal relationships'.[56] Osmond developed a set of guidelines based on the psychological and behavioural needs of patients which included privacy, choice, the reduction of uncertainty and beneficial social relationships.

With its emphasis on principles of planning and design, the 'Saskatchewan plan' was becoming increasingly influential in the work of the ASP.[57] In 1954, there had been a flurry of correspondence and a sharing of information with Osmond and Izumi.[58] As the programme of modernisation progressed at Weyburn, the ASP solicited the plans of Izumi's innovative semi-circular designs for a nursing unit that tackled the problem of corridors while providing patients with freedom of movement, stimulation and meaningful interactions with staff.[59] The ASP pushed for its publication in *Mental Hospitals* with a complimentary article by Osmond described as a 'think piece', Ozarin declaring: 'I think architects are begging for this kind of information [on] principles

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[56] Ibid., 25, 28.

[57] The plan involved breaking up and dispersing psychiatric facilities and had a central architectural component. For an insightful, extensive and detailed analysis of this and the work of Osmond and Izumi more generally, see the work of Erika Dyck on which this paper draws—Erika Dyck and Alexander Deighton, *Managing Madness: Weyburn Mental Hospital and the Transformation of Psychiatric Care in Canada* (Winnipeg: University of Manitoba Press, 2017) and Erika Dyck, "Spaced-Out in Saskatchewan: Modernism, Anti-psychiatry, and Deinstitutionalization 1950–1968," *Bulletin of the History of Medicine* 84 (2010): 640–66. Dyck notes that the rapid pace of deinstitutionalisation in Canada meant that little was built.

[58] For example, Guttersen sent Izumi reprints of type plans and suggested useful hospitals for him to visit. Guttersen to Izumi August 9, 1954, ASP Papers, Folder 54. The following year, he provided information on dormitory spaces and nursing units and suggested the need for a 'master plan.' Guttersen to Osmond, January 12, 1955, ASP Papers, Folder 54. Smalldon had been advising Osmond on design issues regarding security and group sizes since late 1953. Smalldon to Osmond, October 7, 1953, ASP Papers, Folder 77.

[59] Ozarin to Izumi, November 13, 1956, ASP Papers, Folder 54.

and philosophy'.[60] The Saskatchewan plan was the focal point of the first mental hospital design clinic in 1958, jointly sponsored by the ASP and AIA to 'lead to a set—not of blueprints—but of principles of good psychiatric hospital design'.[61] In their joint presentation, Izumi explained how his design had fulfilled the principle of 'sociopetality', as developed by Osmond, in which stable interpersonal relationships were fostered through a design that encouraged small group formation and face-to-face contact. Socio-petal space, designed to bring people together and foster communication and cooperation, was contrasted with the socio-fugal, which drives people apart, and 'prevents or discourages the formation of stable human relationships'. This was a quality that, while necessary in some urban buildings, had been become too common in the 'monstrous' mental hospitals of the recent past.[62]

The work at Saskatchewan embodied what Goshen described as the 'new look' being brought to the ASP, as they sought to 'define more clearly what the psychiatric requirements of design are, or what we hope them to become'.[63] It helped to bring much-needed conceptual and methodological advance and encouraged a functional and research-based approach. It also showed how it was possible to translate principles into plans, blueprints, bricks and mortar. Goshen edited the ASP's final contribution, *Psychiatric Architecture*, published in 1959 with the last of their funds from the NIMH, a text which collected together a selection of innovative designs and processes such as furnishing and soundproofing, and highlighted the wide range of potential facilities for rehabilitation. It was a text in which the Saskatchewan plan had a prominent place, Osmond providing two of the papers focused on the relationship between psychiatry and architecture. While the ASP had struggled in its search for coherence, Goshen now declared that its 'most important aim

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[60] Ozarin to Osmond, January 24, 1957, and Ozarin to Osmond, December 19, 1956 ASP Papers, Folder 54.

[61] "New Trends in Psychiatric Architecture—The First Mental Hospital Design Clinic", sponsored by the ASP and AIA, Washington, DC, January 16–17, 1958, ASP Papers, Folder 91. The clinic also included three further reporting teams from Ohio, Indiana, and Delaware, but it was Saskatchewan, represented by Osmond and Izumi, and recipient of the APA's Hospital Improvement Award, that was the focal point of the discussion.

[62] Osmond, "Function as the Basis of Psychiatric Ward Design", 28, 23.

[63] Charles Goshen, "Progress Report," October 30, 1957, ASP Papers, Folder 120.

[was] the development of effective communication between the two main professions concerned—psychiatry and architecture'.[64] To this, Osmond added a request for 'the help of colleagues in other disciplines'.[65] As we shall now examine, it was this much broader interdisciplinary endeavour, focused on the relationship between the physical environment and mental health, that would continue to use psychiatric spaces as critical sites for controlled investigation. In turn, the focus on the mental hospital would help establish territory, privacy and personal space as key principles for the study and design of a wide range of institutional and urban spaces.

Principles of Privacy, Territory and Personal Space in Built Environments

Among significant changes that took place in the mental health field in the post-war era was the growing influence of the social and behavioural sciences, funded extensively through the NIMH. Andrew Scull sees sociologists and psychologists as having 'contributed extensively to the loss of legitimacy that institutional psychiatry experienced'. Critical to this loss, Scull argues, was the pessimistic portrait of the mental hospital painted by those such as Goffman.[66] The mental hospital did, however, continue to make a more positive contribution to this very movement away from institution that gathered pace in the 1960s, with the growth of community mental health programming. It continued to serve as a site that brought different disciplines and professions together to focus on the relationship between environment and behaviour and a place where ideas, concepts and principles could be generated and tested through observation and experimentation.

The social and political upheavals of the 1960s may have contributed to the decline of the total institution, yet they also generated a new appreciation of the environment, be it natural spaces threatened by pollution, crowded cities, or suburban sprawl. When it came to the built environment, Robert Sommer declared:

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[64] Charles Goshen, "A Review of Psychiatric Architecture and the Principles of Design," in *Psychiatric Architecture: A Review of Contemporary Developments in the Architecture of Mental Hospitals, Schools for the Mentally Retarded and Related Facilities*, ed. Charles Goshen (Washington, DC: The American Psychiatric Association, 1959), 1–6 (1).

[65] Humphry Osmond, "The Historical and Sociological Development of Mental Hospitals," in *Psychiatric Architecture*, ed. Goshen, 7–9 (9).

[66] Scull, "Psychiatry and the Social Sciences, 1940–2009," 37.

> The clearest realization of the connection between environmental form and human behavior is taking place in the institutional field. People… are surprised to find that decisions regarding the physical plant amounting to tens of millions of dollars are made without adequate information about user behavior. Whether it is a matter of separate or bunks beds in college dormitories, secluded or exposed nurses' stations in hospitals, open or partitioned offices, ceilings eight or eight-and-one-half feet in apartments, it is evident that little is known as to how the alternatives affect people.[67]

In this statement, Sommer moves deftly from the institution to the modern apartment building and, therefore, from the hospital to the city. While earlier attempts to humanise the mental hospital had attempted to make it more 'homelike' and thus more like the world outside, there was now a reversal of roles; the hospital was reinterpreted as a critical site for the development of principles that were not only relevant to all psychiatric services, but to a wide variety of urban spaces in this new era of preventative mental health.

Sommer was also identifying the demand for design information that was coming from administrators and managers of institutions which, in turn, placed pressure on architects and planners. This pressure was considerable in an era of expanding urban and suburban development, increased population density and an accelerated pace of life, and with it, growing fears of a mass society in which speed, impersonality and uniformity became the norm. Concern intensified in the 1960s with the growing fear of violence and crime in the era of 'urban crisis'. Architects were beginning to organise in response. In the late 1950s, the AIA established a Committee on Research for Architecture to 'contribute to the public welfare through better building in both the physical and esthetic sense'.[68] And yet, as the environmental analyst and designer Mayer Spivack noted, architecture and the design disciplines 'offer us very little in the way of reliable and sophisticated conceptual and design tools'.[69] Advisors to the AIA such as the sociologist Robert

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[67] Sommer, *Personal Space*, 9.

[68] "Special Report no. 4, A Statement on Architectural Research by the AIA Committee on Research, AIA," May 1956, Martin Allen Pond Papers, Yale University Library, Box 12, Folder 227.

[69] Mayer Spivack, "Some Psychological Implications of Mental Health Center Architecture," 1966, Archives of the Environmental Research and Development Foundation (hereafter ERDF Papers), Kenneth Spencer Research Library, University of Kansas, Box 58, 2600. Spivack also drew from ethologists such as Hediger.

Merton suggested a 'clinical' approach, in which, just like the physician, the architect drew upon a variety of sciences to solve 'classes of recurrent problems'.[70] In order to understand the psychological impact of the environment, one AIA group declared: 'we need the help of behavioral science skills and techniques'.[71] Psychologists reciprocated in turn, concerned to move beyond the 'contrived settings' of the laboratory and address social problems in the 'real world'.[72] The result was the intensely interdisciplinary field of architectural or environmental psychology, supported largely by the NIMH, and described simply by one of its leading early figures as: 'The psychological study of behavior as it relates to the everyday physical environment'.[73]

While the field of environmental psychology emerged in the 1960s, its origins lay in the work of the 1950s. Sommer was a pioneer and Osmond's paper published in *Mental Hospitals* was considered field defining. Sommer continued to work with Osmond's concepts and apply them to a range of institutions and environments. Using naturalistic observation, experiment and interview, he examined how space was controlled by individuals and the effects on intrusions into what he defined as 'personal space', an area that surrounded a person's body. These were a further advance on methods originally developed in the mental hospital, such as his studies of seating arrangements to understand user behaviour and model the right kinds of spaces on a geriatric ward.[74] The development of the invasion technique, where the researcher would sit too close to individuals and gauge their

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[70] R. K. Merton to Walter E. Campbell, AIA, November 4, 1957, Pond Papers, Folder 227.

[71] "Report A," in *Research for Architecture, Proceedings of the AIA-NSF Conference, Ann Arbor, Michigan, 10–12 March 1959*, ed. Eugene F. Magenau (Washington, DC: AIA, 1959), 90. Attendees expressed much support for such interaction.

[72] William H. Ittelson, H. M. Proshansky, L. G. Rivlin, and G. Winkel, *An Introduction to Environmental Psychology* (Oxford: Holt, Rinehart & Winston, 1974), 71; Harold M. Proshansky, "Environmental Psychology and the Real World," *American Psychologist* 31 (1976): 303–10.

[73] Kenneth Craik, "The Prospects for an Environmental Psychology," Draft, for *Journal of Environmental Design*, ERDF Papers, Box 55, 2154.

[74] For a much more detailed analysis of Sommer's work at Weyburn, see John A. Mills and Erika Dyck, "Trust Amply Recompensed: Psychological Research at Weyburn, Saskatchewan, 1957–1961," *Journal of the History of the Behavioral Sciences* 44 (2008): 199–218.

response, was made possible in the mental hospital, ‘a place where the usual sanctions of the outside world did not apply’.[75] Once refined, Sommer transferred these techniques to a wide range of spaces, from college libraries to airport terminals, and argued that the spatial principles developed had universal relevance. When he turned his attention to ‘softening’ correctional architecture, he compared, as he so often did, the ‘barren, cold, or hard’ conditions where inmates were treated ‘worse than… zoo animals’, to those of mental hospitals before their research at Saskatchewan had helped to overcome the state of inertia and neglect.[76]

Sommer also drew from continuing research in the mental hospital such as the ethologically informed work of psychiatrist Aristide (Hans) Esser on a psychiatric ward in the Rockland State Hospital, New York.[77] Patients were observed according to a strict time-sample and their location, posture and interaction recorded with code on maps of the ward divided into a grid of 3 × 3 foot squares. The processed information gave them a breakdown of each patient’s movement and interactions. Esser argued that, just as in nature, ‘an ordering principle occurs’ based on territoriality and a dominance hierarchy. The way in which patients used space was related to their social rank—the more dominant moved freely around the ward, while the weaker and more withdrawn established their own restricted ‘definite territories’ which they defended aggressively.[78] The mental hospital offered a unique opportunity for understanding this very complex process of social ordering in relation to space, as the ‘chronically mentally ill… are incapable of and are not allowed to participate in most role relationships. Clearly revealed is the simplicity of their aggressive behaviour related to defence of property

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[75] Sommer, *Personal Space*, 31–32.

[76] Robert Sommer, “Final Report: Research Priorities in Correctional Architecture,” July 1, 1970–December 30, 1970, ERDF Papers, Box 28.

[77] This was reciprocated with Esser drawing on Sommer’s seating techniques—Richard Almond and Aristide H. Esser, “Tablemate Choices of Psychiatric Patients: A Technique for Measuring Social Contact,” *Journal of Nervous and Mental Disease* 141 (1965): 68–82. Esser was also influenced by Osmond and Izumi—Aristide H. Esser, “Environmental Design Needs Empathy to Combat Pollution,” to appear in *Matrix*, 1971, ERDF Papers, Box 47, 3669.

[78] Aristide H. Esser et al., “Territoriality of Patients on a Research Ward,” in *Biological Advances in Psychiatry*, ed. Joseph Wortis (New York: Plenum, 1965), 37–44 (37).

and rank'.[79] The mental hospital had further advantages, as not only was the territorial behaviour 'unmasked' or 'undisguised', but the ward was both a 'closed' setting in which variables were relatively constant and a 'natural habitat' unlike the artificial setting of the laboratory.[80] The ward was a hybrid space, a natural experiment that allowed them to interrogate the functions of spatial behaviour from the vantage point of the nurses' station, Esser noting just how easy 'systematic observation' was in 'our specially designed observation area'.[81] It also, of course, generated principles such as territoriality that could inform the design of environments to sustain communal living in 'the increasingly crowded conditions in our technological world'.[82] To help achieve these aims, Esser founded and directed the Association for the Study of Man-Environment Relations in 1968 and edited the journal *Man-Environment Systems*, both important to the development of environmental psychology.[83]

So central was research in mental hospitals that all three of the first centres for environmental psychology that emerged in the 1960s did so as a direct consequence of research in spatial behaviour and design in the psychiatric ward. The most prominent, and the first to offer graduate training, was based at the Graduate Centre of the City University New York (CUNY). It emerged through a series of NIMH grants, beginning in 1958, to a research team to study mental hospital design led by a psychologist of perception, William Ittelson, at Brooklyn College. The purpose, as one member described it, was to 'be able to tell some architects *how* to build a mental hospital so the patients will get cured much faster'.[84] But of course it was not so simple. They described how 'questionable assumptions' were stripped

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[79] Aristide H. Esser, "Interactional Hierarchy and Power Structure on a Psychiatric Ward: Ethological Studies of Dominance Behaviour in a Total Institution," in *Behavior Studies in Psychiatry*, eds. Sidney J. Hutt and Corrine Hutt (Oxford: Pergamon Press, 1970), 25–59 (42).

[80] Esser, "Interactional Hierarchy."

[81] Ibid., 43.

[82] Aristide H. Esser, "Social Contact and the Use of Space in Psychiatric Patients," Abstract, AAAS Meeting, 1965, ERDF Papers, Box 54, S.1692.

[83] John Zeisel, "Behavioral Research and Environmental Design: A Marriage of Necessity," *Design & Environment* 1 (1970): 51–66.

[84] Proshansky, "Environmental Psychology," 303.

away and they were forced to 'postpone the question' of design and turn instead to explore how the hospital environment was experienced by patients.[85] An extensive research programme was undertaken and they developed an even more sophisticated technique of 'behavioural mapping'. This not only involved time-sampling with multiple observers recording behaviour during a predetermined period in the wards of three hospitals, but also included a more formal series of 'behavior categories' to establish 'types' such as the 'isolated passive', a withdrawn individual either lying in bed or sitting alone.[86] This isolation was, they suggested, a consequence of the individual's failure to control space and establish territory and privacy and so attain 'freedom of choice' in behaviour. The implications for design were that single or double bedrooms were preferable, as they encouraged social interaction on the patient's own terms and thus hastened recovery. These studies were not only relevant to the design of psychiatric facilities, but, as the researchers made clear, they also had taken a step 'toward developing general principles applicable to a variety of settings'.[87]

The CUNY research group described the mental hospital as the catalyst for the development of a field 'born of social necessity'.[88] Lawrence Good was also funded by the NIMH to model the renovation of a ward in Topeka State Hospital, Kansas in 1962.[89] Some of the anthropologists, psychologists and sociologists brought together for the project founded the Environmental Research Foundation in 1965 which soon

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[85] Harold M. Proshansky, William H. Ittelson, and Leanne G. Rivlin, "The Influence of the Physical Environment on Behavior: Some Basic Assumptions," in *Environmental Psychology: Man and His Physical Setting*, eds. Proshansky, Ittelson, and Rivlin (New York: Holt, Rinehart and Winston, 1970), 27–37 (27).

[86] William H. Ittelson, Harold M. Proshansky, and Leanne G. Rivlin, "Bedroom Size and Social Interaction of the Psychiatric Ward," *Environment and Behavior* 2 (1970): 255–70.

[87] William H. Ittelson, Harold M. Proshansky, and Leanne G. Rivlin, "The Environmental Psychology of the Psychiatric Ward," in *Environmental Psychology*, eds. Proshansky, Ittelson, and Rivlin, 419–39 (424).

[88] Proshansky, Ittelson, and Rivlin, "The Influence of the Physical Environment on Behavior," 27.

[89] "The Foundation's Work in the Area of Mental Health Care Environments," ERDF Papers, Box 7.

'expanded its research scope into urban problems'.[90] Finally, a doctoral programme in architectural psychology was established at the University of Utah following a series of conferences on mental hospital design. Its co-director, Roger Bailey, again emphasised how research focused on the relations between the architectural environment and patient behaviour had 'wide application in the other fields of architecture'.[91]

The wider relevance of principles of psychiatric architecture was captured by a comparative piece in the magazine *Progressive Architecture* in 1965. This brought together an architect and psychiatrist in an investigation of two environments—a mental hospital and a college campus. The recent appointment of architect Robert Geddes as Dean of the School of Architecture at Princeton was considered 'significant, for it implies a new direction in architectural education, in which the study of the behavioral and social sciences will become an integral part of the curriculum'.[92] Geddes was strongly influenced by Osmond, now at Princeton, and involved him in a mental hospital study carried out by his students which included materials by the ASP. The purpose of having students design for the mentally ill, and its relevance to the hall of residence designed by Geddes, was to demonstrate how Osmond's principles of social design were 'in effect, applicable to all architecture that involves people, whether in office buildings, in apartment houses, or, as in their case, in a college complex'.[93] It was necessary to design spaces in ways that encouraged social interaction but also ensured that individuals were

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[90] Robert B. Bechtel, *Environment and Behavior: An Introduction* (London: Sage, 1997), 84. See also Lawrence R. Good, Saul M. Siegel, and Alfred Paul Bay, eds., *Therapy by Design: Implications of Architecture for Human Behavior* (Springfield, IL: C.C. Thomas, 1965). The Environmental Research Foundation became the Environmental Research and Development Foundation (ERDF) in 1970. Of considerable importance to their philosophy was the work of Roger Barker at the Midwest Psychological Field Station in Kansas, which grew out of research into child development. Barker's observation techniques and concepts made field studies work amenable to the production of objective data on behaviour. Also critical was the work of the anthropologist Edward Hall on proxemics which served to unite disciplines around the study of spatial behaviour and communicate ideas and methods to a broad audience—see Edward Hall, *The Silent Language* (Garden City: Doubleday, 1959).

[91] Roger Bailey, "Needed: Optimum Social Design Criteria," *The Modern Hospital* 106 (1966): 101–3 (103).

[92] "The Psychological Dimension of Architectural Space," *Progressive Architecture* 46 (1965): 159–67.

[93] Ibid., 163.

not overwhelmed by unwanted social contact, otherwise ‘friendships and social groups do not form’.

Osmond advised on many other similar projects, the majority funded by the NIMH, as the behavioural sciences became increasingly influential in architectural departments, organizations and practices in the interests of promoting mental health and social well-being. He was listed as an advisor to a project devised by Mayer Spivack and others at the Laboratory of Community Psychiatry, Harvard Medical School, which was aimed at providing evidence for improved architectural practices and design criteria ‘at a critical time’ for the NIMH and the new mental health centres.[94] But the grant application captured, once again, a much broader vision. With the acute sensitivity of the ‘emotionally disturbed individual’ to spatial factors, they could be used as ‘probes’ to explore the environment. Thus, the naturalistic studies of the ward could provide ‘optimum’ specifications for ‘architectural and urban spaces in general’ and generate a better understanding of the ‘relationship between the physical environment and its influence on the minds and movements of men’. Once again, the psychiatric facility served as an ideal, valid and intact setting for the investigation and design of functional spaces. The knowledge gained would, they anticipated, feed back into the ‘design of urban structures in general… correctly classified as preventative mental health for our increasingly urbanized population’.

Conclusion

In 1968 the social psychiatrist Leonard Duhl published a paper entitled ‘The shame of the cities’.[95] The title acknowledges Deutsch’s earlier exposé of the state mental hospital, now reworked by one of the leading promoters of preventative mental health to focus attention onto ‘failure’

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[94] “The Effects of Physical Settings on Patient Behavior,” research grant application, 1967, ERDF Papers, Box 58, 2710. Spivack was named as the proposed project’s director and the principal investigator was sociologist Harold Demone, Jr. Notably, both the application and Spivack’s work in general drew strongly from ethological ideas. For an important analysis of the architectural design and function of the Community Health Centre as a critical technology in the transition from a clinical to a public health model in psychiatry, see Joy Knoblauch, “The Permeable Institution: Community Mental Health Centers as Governmental Technology (1963 to 1974)”, in Delia Duong Ba Wendel and Fallon Samuels Aidoo, eds., *Spatializing Politics: Essays on Power and Place* (Cambridge: Harvard Graduate School of Design, 2015).

[95] Leonard J. Duhl, “The Shame of the Cities,” *American Journal of Psychiatry* 124 (1968): 70–5.

in the ‘real world’ at the height of the urban crisis with American cities blighted by sickness, stress, violence, and poverty.[96] And yet, for an emerging group of environmental psychologists, mental hospitals had done much more than stimulate, through their obsolescence, a turn away from custodial care; they had played a critically important role in building, adapting and refining the tools needed to address many of the problems that now inflicted the wider urban environment, problems with which experts and policy-makers were struggling to deal. When Lucy Ozarin reflected on the rise of collaborative efforts between architects and psychologists to design for mental health, she made a point of beginning with the ASP’s early studies of patients and staff, its consultation and publications as central to an ‘intensive campaign to improve existing psychiatric facilities’.[97] Similarly, when William Ittelson considered a programme of research for architecture, he reflected on his own studies of the psychiatric ward and argued that they had ‘a vast laboratory of already completed structures for study. All we need to know is how to go about doing it.’[98]

The mental hospital was a particularly important ‘laboratory’ for the development of concepts and methods to explore the social and psychological aspects of the built environment. Kohler argues that the key characteristic of a laboratory is its ‘placelessness’; its ability to generate objective knowledge and generalisation stems from ‘stripped down-simplicity and invariability’.[99] The laboratory gives the experimenter close control over material and ‘when place affects laboratory experiments we know that something went wrong’.[100] The mental hospital, with its separation from the outside world and its ‘clearly delineated physical and social system’, offered an impressive degree of control.[101]

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[96] Harold M Proshansky, “The Field of Environmental Psychology: Securing the Future,” in *Handbook of Environmental Psychology*, eds. Daniel Stokols and Irwin Altman, v. 2 (New York: Wiley, 1987).

[97] Lucy Ozarin, “Notes on the Development of Collaboration Between Architects and Clinicians,” *Hospital & Community Psychiatry* 31 (1980): 276–77 (277).

[98] Ittelson, Discussion in Magenau, ed., *Research for Architecture*, 38. To this end, the architect Walter Taylor noted, they had been working closely with the APA in their research and in their ‘clinic conferences’ for design of mental hospitals.

[99] Kohler, *Landscapes*, 7.

[100] Ibid., 9.

[101] Ittelson, Proshansky, and Rivlin, “The Environmental Psychology of the Psychiatric Ward,” 419.

The carefully regulated systems of time, space and function allowed behaviour patterns in the hospital's uniquely sensitive population to be identified, controlled and manipulated, such as in Sommer's experimental altering of furnishings, for example, or in the comparison between an original and refurbished ward. But, of course, at the same moment the complexity of place, of real and intact settings, was critically important, and many psychologists were dismissive of laboratory studies for their neglect of social and physical context of behaviour. While the mental hospital granted researchers a significant degree of control, it was also a natural setting representative of the 'real world' which so concerned environmental psychologists. The mental hospital was a 'hybrid' space that contained elements of both laboratory and field. Blain described the institution as 'part laboratory, in part hospital in the traditional sense, in part convalescent home, in part rest-home, in part university, and overall, as has been said "an institution where we teach the patients how to live"'.[102] It was, as one environmental psychologist pointed out, 'in many ways a microcosm' of wider society that 'reflects within its own organization many of the larger unsolved complexities of urban life as a whole'.[103]

The credibility of the mental hospital as a site for generating principles for design was further reinforced by the interpretation of the world as a multitude of comparable spaces, the city now broken into a series of settings to which the methods and concepts for understanding the spatial behaviour of the psychiatric patient could be usefully transferred. 'In fact', environmental psychologists declared, 'a large part of our lives is spent in institutional settings of one kind or another, and the qualities that make a setting institutional imply some common effects on behavior'.[104] The understanding of territorial behaviour and personal space that had been established on the psychiatric ward (and which had been informed by the zoo) could be applied to the general hospital, prison, classroom, dormitory and even family apartment. In public housing developments, an understanding of territoriality was deemed critical to building more cohesive communities that promoted mental health and

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[102] Daniel Blain, "Psychiatric Facilities of the Future," n.d., ASP Papers, Folder 98.

[103] Roslyn Lindheim, "Factors Which Determine Hospital Design," in *Environmental Psychology*, eds. Proshansky, Ittelson, and Rivlin, 573–79 (573–74).

[104] Ittelson et al., *An Introduction to Environmental Psychology*, 368.

prevented crime.[105] In this way, the study of psychiatric architecture fulfilled the broader ambitions of the ASP. The 'immediate need' of improving the therapeutic potential of psychiatric facilities had brought together, for the first time, a diverse group of psychiatrists, architects and behavioural scientists who had then worked to contribute a broader and more basic understanding of spatial behaviour in the context of mental health.[106] As the ASP turned to 'principles' of 'functional design' to address the problems of psychiatric treatment, 'by the same token', its members suggested, 'psychiatric thinking can be related to architectural and community design in a general way'.[107] The principles established in the context of the mental hospital could be incorporated into 'homes, schools, factories, public buildings and community projects'. The ASP had identified the very obsolescence of the mental hospital as offering a 'tremendous field for the architect's imagination, putting the architect in a position to make a significant contribution to both psychiatry and society'.

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[105] On this important application of ideas of territoriality to the design of urban spaces, see Joy Knoblauch, "The Economy of Fear: Oscar Newman Launches Crime Prevention through Urban Design (1969–197x)," *Architectural Theory Review* 19 (2015): 336–54.

[106] Ittelson, Proshansky, and Rivlin, "The Environmental Psychology of the Psychiatric Ward," 419.

[107] The Psychiatric Architecture Design Contest, 1957, ASP Papers, Folder 118. This was a contest open to students of architecture to encourage interest in psychiatric architecture, and was organized around a series of 'principles'.

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CHAPTER 11

Newgenics and the Politics of Choice: A Historical Look at Canada's Psychiatric Institutions in the 1970s

Erika Dyck

EUGENICS AND DISABILITY IN CANADA

In Canada, two provinces formally enacted eugenics laws: Alberta's Sexual Sterilization act was in place from 1928 to 1972 and sterilised nearly 3000 people; 55 people were sterilised in the last year of the programme (77 were approved).[1] British Columbia's law was passed in 1933 and was repealed 40 years later in 1973, but its programme never fully enjoyed support, meaning that there was no comprehensive institutional network or administrative resources allotted to the programme. The scant archival record that remains suggests that approximately 200 women were sterilised (I found no men in this case). The Law Reform Commission of Canada reported in 1979 that these programmes had

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[1] Law Reform Commission of Canada, "Protection of Life: Sterilization: Implications for Mentally Retarded and Mentally Ill Persons," Working paper 24, 1979, 27.

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Mental Health in Historical Perspective,
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been justified in part in an effort to relieve the economic burden of long-term care and social services.[2] But, the Commission also explained that there were distinct advantages to non-consensual sterilisation: 'removal of the threat of parenthood with which the mentally handicapped may be unable or unprepared to cope; inability of the mentally handicapped to bear the financial burden that accompanies rearing children; and for reasons of personal hygiene'.[3]

These claims about irresponsible parenthood restored eugenic ideas while shifting the language of prevention from hereditary causes to social and economic ones. The legal justifications in effect reinstated the concept of eugenics, or as some scholars have more recently suggested, a form of newgenics, that is, the re-emergence of eugenic logic. Some activists suggest that by using this term, we acknowledge the connections to the eugenic past and recognise that contemporary strategies to control fertility or remove children from parents with intellectual or psychiatric diagnoses is a continuation of eugenic practices.[4] Historically, eugenics reformers argued that despite the discredited science of heredity, the notion that people with mental disorders were unfit parents remained paramount and helped to justify continued surveillance of their sexual activities in an effort to prevent future generations of people with mental disorders, low intelligence scores, mental deficiencies or a litany of disorders and disabilities that might fall under the umbrella of undesirable behaviours.

Although historically only two Canadian provinces had formal laws regarding non-consensual sterilisation, the practice was much more widespread. Psychiatric and training school facilities in eastern Canada had long segregated women of childbearing age in the mental health system in an effort to control pregnancy. Ontario had relied on similar approaches but by 1964 began widely using injections of Depo-Provera (a manufactured hormone used chiefly for birth control) on an experimental basis to stop menstruation in fertile women confined to institutions. The rationale behind these practices remained consistent with claims outlined in the Law Commission, reinforcing the idea that the state allegedly played a compassionate if paternalistic role in preventing

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[2] Ibid., 29.

[3] Ibid., 31.

[4] For examples of this line of reasoning, see interviews with disability activists, especially Nicola Fairbrother, http://eugenicsarchive.ca/discover/interviews, accessed 20 January 2018.

pregnancy among this population of people considered too ill or too incapacitated to make decisions for their own benefit. And, by extension, these individuals were considered unfit for parenting with a higher than average likelihood of producing dependent children who, like their parents, would continue to rely heavily on the state for assistance. Breaking this cycle of dependency, which was intimately linked to notions of mental deficiency and disorder, remained firmly entrenched in the decisions to restrict the fertility within this subsection of the population.

In this chapter, I build on some of the historical literature that explores how ideas of eugenics transformed in the second half of the twentieth century and comingled with ideas of reproductive health, notably work by Rebecca Kluchin, Johanna Schoen and Wendy Kline.[5] The historiographical focus on eugenics more often focuses on its earlier manifestations, the explicit sterilisation programmes that played out on marginalised bodies up to the Second World War. In Canada, that has meant concentrating on institutionalised populations in Alberta and British Columbia where the Sexual Sterilization acts specifically targeted people confined to mental hospitals or training schools for mental deficiency.[6] This literature is often separate from the historiography on

[5] For examples of scholarship on this topic, see Rebecca Kluchin, *Fit to Be Tied: Sterilization and Reproductive Rights in America, 1950–1980* (New Brunswick, NJ: Rutgers University Press, 2009); Johanna Schoen, *Choice and Coercion: Birth Control, Sterilization, and Abortion in Public Health and Welfare* (Chapel Hill: University of North Carolina Press, 2005); Wendy Kline, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2001).

[6] Erika Dyck, *Facing Eugenics: Sterilization, Reproduction, and the Politics of Choice* (Toronto: University of Toronto Press, 2013); Claudia Malacrida, *A Special Hell: Institutional Life in Alberta's Eugenic Years* (Toronto: University of Toronto Press, 2015); Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885–1945* (Toronto: McClelland & Stewart, 1990); Jana Grekul, "Social Construction of the 'Feeble-Minded Threat'" (Ph.D. diss., University of Alberta, 2002); Tim Caulfield and Gerald Robertson, "Eugenic Policies in Alberta: From the Systematic to the Systemic?" *Alberta Law Review* 35, no. 1 (1996): 59–79; Terry Chapman, "Early Eugenics Movements in Western Canada," *Alberta History* 25, no. 4 (1977): 9–17; Cecily Devereux, *Growing a Race: Nellie L. McClung and the Fiction of Eugenic Feminism* (Montreal and Ithaca, NY: McGill-Queen's University Press, 2005); Jane Harris-Zsovan, *Eugenics and the Firewall: Canada's Nasty Little Secret* (Winnipeg: J.G. Shillingford, 2010); Leilani Muir, *A Whisper Past: Childless After Eugenic Sterilization in Alberta, A Memoir by Leilani Muir* (Victoria, BC: Friesen Press, 2014); Amy Samson, "Eugenics in the Community: Gendered Professions and Eugenic Sterilization in Alberta, 1928–1972," *Canadian Bulletin for Medical History/Bulletin canadien d'histoire de la médecine* 31, no. 1 (2014): 143–63.

deinstitutionalisation, disability and the changing contours of the mental health system in the 1970s, but here, I bring them together to highlight how questions of mental health and its prevention continued to condition reproductive choices. By focusing on the archival papers, newspaper coverage and legal decisions surrounding the issue of sterilisation for individuals considered intellectually disabled, I construct a narrative interpretation of how eugenic ideas and the politics of choice collided in the 1970s, particularly for women who were considered incapable of making rational choices.

The context of the debates over reproductive rights had changed significantly in the 1970s. Before the Second World War, at a time when all contraception and abortion were also illegal, the concept of eugenics was a broad brush that included advocates for coercive as well as voluntary forms of birth control and fertility restriction. The federal government changed the Criminal Code in 1969 and relaxed its laws on contraception and abortion, offering some supporters of eugenics the opportunity to claim victory, both morally and politically, by decriminalising the use of birth control. The language of eugenics, however, had become tarnished by association with the Holocaust and with draconian images of coercive sterilisations, primarily those occurring in the thousands in psychiatric and penal institutions around the world.[7] By the 1970s, the word eugenics more often connoted an image of paternalistic control over marginalised bodies, while second-wave feminists embraced some of the same technologies, including sterilisation, and rebranded it as an operation of liberty from those same patronising forces.

By the 1970s, legally, contraception and abortion were permitted. It is perhaps not surprising that the provinces that still had eugenics programmes in place were among the first to respond with provincial commissions inquiring into the overlap and distinction between sterilisations performed on people considered incompetent and those permitted for

[7] Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997); Alexandra Stern, "From Legislation to Lived Experience: Eugenic Sterilization in California and Indiana, 1907–79," in *A Century of Eugenics in America: From the Indiana Experiment to the Human Genome Era*, ed. Paul Lombardo (Bloomington: Indiana University Press, 2011); Paul Weindling, *Victims and Survivors of Nazi Human Experiments: Science and Suffering in the Holocaust* (London: Bloomsbury, 2014); and Marius Turda, ed., *The History of East-Central European Eugenics, 1900–1945: Sources and Commentaries* (London: Bloomsbury, 2015).

healthy men and women. While attitudes towards contraception for healthy bodies relaxed, however, concerns about fertility among people considered mentally disabled, which generically applied across categories of mental illness and intellectual disability, occasioned further debate.

According to the Institute of Law Research and Reform, based in Edmonton, Alberta:

> The repeal in 1972 of the Sexual Sterilization act, … ended a dark chapter in the history of the mentally disabled in Alberta. Drafted to protect the gene pool with no consideration of individual rights, this Act had allowed sterilisation of mentally disabled persons without their consent. This discredited legislation has contributed greatly to the political sensitivity of this issue; no one wants a return to what amounted to forced sterilisation.[8]

The legal inquiries in the 1970s emphasised that science and the law had moved beyond the crude approximations of human inheritance and intelligence that had once guided the architects of eugenics programmes. The reports implied that future clinical interventions, including sterilisations, would be better informed by scientific evidence and sound public policy that prioritised the rights of individuals more directly over the concerns of the state, even as those concepts remained loosely defined. But, this language of liberation did not simply translate into reproductive choices for everyone.

Alberta was in some ways on the hot seat in these debates, having as recently as 1969 defended their eugenics programme, claiming that it both saved the province money and was built on sound scientific evidence. The latter was disputed by leading geneticists, but the Social Credit government had remained committed to the programme until they were defeated in 1971 by the Conservatives, who quickly moved to dismantle the programme. But, in 1978, that government introduced a new law that allowed parents and guardians of people declared mentally incompetent to recommend sterilisation on their behalf. This option of electing non-therapeutic sterilisation surgery was in keeping with mainstream society's menu of contraceptive choices, but the creation of a third-party decision-making structure complicated the situation. It suggested that parents of disabled or disordered children remained

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[8] Institute of Law Research and Reform, Edmonton, AB, *Competence and Human Reproduction*, Report 52 (February 1989), 2.

apprehensive about preventing reproduction that may result in further dependency, whether that be on grandparents or the state or both.

The Dependent Adults Act allowed sterilisations to continue on a population of people in psychiatric facilities and those considered mentally incompetent or intellectually disabled, with the newly added layer of consent by proxy or consent from parents or guardians. Once again, Alberta made some bold legal strides by codifying these practices in law, but other jurisdictions embraced similar practices without passing specific policies. For example, on 24 April 1973, an employee of the Metropolitan Toronto Association for the Mentally Retarded proposed that anyone seeking financial support for sheltered or subsidised housing on account of mental disability should be sterilised as a condition of their acceptance into that funding programme. The Ontario director of such facilities opposed this proposal but was later forced to resign.[9] That same year, female residents of the Ontario Hospital [Training] School at Cedar Springs were denied tubal ligations at the local general hospital. The patients were all over the age of 18 and deemed incapable of giving informed consent. In this instance, the hospital struck a Committee on behalf of the 'retarded patient', as defined in the report, to adjudicate these requests on a case-by-case basis,[10] thus creating another variation on third-party consent, but also exposing some of the philosophical contests over the right to choose and the right to protection. By the end of the decade, Ontario's health minister, Dennis Timbrell boldly suggested abolishing all sterilisations of minors and individuals with mental disabilities. The Canadian law commission softened this interpretation, declaring that mentally incompetent individuals should not be sterilised against their will.[11]

Provinces, however, struggled to draw a clear legal line, dividing competency from incompetency as it pertained to consent for sterilisation, which some wanted to extend to include experimentation, transplantation and psychosurgery.[12] Rather than deferring decisions to parents or guardians, the national law commission recommended the transfer of

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[9] Provincial Archives of Ontario, 1973. Memo to Mr. W. Darcy McKeough, MPP. From Robert Welch, Provincial Secretary.

[10] Provincial Archives of Ontario, Memo to: The Hon. R. Welch, Q.C., Provincial Secretary for Social Development. From Hal Jackson, Secretariat for Social Development.

[11] Law Reform Commission of Canada, "Protection of Life: Sterilization," 107, 116.

[12] "Ontario Sterilization Ban Extended in Order to Allow Discussion of Substitute Consent Issue," *Canadian Family Physician* 25 (November 1979): 1285, 1293.

authority to a multidisciplinary board, ‘composed of such people as physicians, lawyers, social workers, psychiatrists and representatives of the public’.[13] The law commission instead looked to clinical professionals to make ‘ethical’ choices on behalf of institutionalised or recently deinstitutionalised patients of childbearing age.

The legal arm of the medical profession in Canada, the Canadian Medical Protection Agency (CMPA), quickly weighed into the debates, particularly out of concern for the impact of these decisions on physicians. One such official from CMPA explained: ‘as you may know, there are those who believe sterilisation of a mentally retarded person is an infringement on civil liberties of the person and that consent for it cannot be properly given by anyone’. He continued by offering legal advice and suggested: ‘although we do not wholly agree with this point of view it must be acknowledged nevertheless that there may be groups or individuals who object strenuously to the principle of sterilisation because of mental incapacity’.[14] Ultimately, the CMPA concluded that ‘the Association has concurred with decisions for sterilisation of mentally retarded minors’,[15] in cases where both parents were in agreement with the decision—in fact, only when parents recommended the operation.

Bringing parents into the equation offered another triangulation of the decision-making process, albeit in a fashion that was familiar to people experiencing institutional life, as parents already played a role in the committal process in most cases. But, this time, the decision was left with parents, who were increasingly responsible for the daily care and/or expense of daily care for their impaired child. As Michel Desjardin has explained, there were considerable double standards when it came to assessing sexuality in people labelled intellectually disabled; their sexuality becomes subject to ‘a series of extraordinary rules, controls, and prohibitions’ including sterilisations, framed as a progressive intervention that permits non-procreative sex.[16]

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[13] Ibid., 1293.

[14] Letter from Dr. Norman Brown, Canadian Medical Protective Association (CMPA), to Dr. Ian Burgess, Vice President Salvation Army Grace Hospital, Calgary, 2 November 1978, Calgary Health Services Archives, Grace Hospital-011, 1.

[15] Ibid., 1.

[16] Michel Desjardin, “The Sexualized Body of the Child. Parents and the Politics of ‘Voluntary’ Sterilization of People Labeled Intellectually Disabled,” in *Sex and Disability*, eds. Robert McRuer and Anna Mollow (Durham: Duke University Press, 2012), 69–85 (79).

Donald Zarfas, former superintendent of the Ontario Hospital School for Children and expert on paediatric 'mental retardation', argued that parents were among the most likely to recommend sterilisation, and consequently should not be given this legal position, because with limited access to custodial care, parents were the most likely to care for grandchildren in the event of procreation. Instead, he argued that children and teens needed advocates and third-party decision-makers to make ethical decisions about their sexual and reproductive lives. Zarfas was a clear advocate for sterilisation, but he stood apart from many of his contemporaries who suggested that individuals with disabilities and low intelligence should be sterilised due to the likelihood of irresponsible parenthood. He, instead, argued that there was wide variation in the capacity to parent among this population and that neither front-line healthcare staff nor parents were in the best position to judge. He suggested that 'it should be someone who can stand back, "stand in the shoes of" and protect the rights of the retarded person'.[17] 'A *citizen* advocate – not a lawyer advocate – someone who could represent the retarded person as an individual', he added.[18]

Importantly, he felt that family members should be consulted but not appointed to make these decisions, as they often 'panic' about their responsibilities associated with an unwanted pregnancy. In other words, Zarfas pushed back against the CMPA's recommendation that parents should shoulder responsibility for decisions about sterilisation because he felt that parents of disabled children feared pregnancy more than anyone. But, by emphasising this feature, Zarfas also contributed to a shift in the discourse that refocused on women as the main subjects for consideration by linking the notion of responsibility to parenting and pregnancy. Although numbers in historical eugenics cases varied, the gender distribution in Alberta only slightly favoured women over men, but by the 1970s, a number of cases of sterilisation in custodial institutions were predominantly performed on women.

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[17] Zarfas as quoted in letter from David Luginbuhl to *Canadian Family Physician*, 1979, Calgary Health Services Archives, GRA-011, 1293.

[18] Ibid. Zarfas elaborates on this concept in: Donald Zarfas, *Orientation Manual on Mental Retardation for Handicapped Individuals, Parents, Volunteers, AMR Members, Students, Citizen Advocates, Youth Groups, Professional Staff* (Toronto: National Institute on Mental Retardation, 1981).

Psychologist Wolf Wolfensberger had recently introduced the concept of a citizen advocate. Wolfensberger aggressively promoted a theory of normalisation, especially concerning individuals with intellectual disabilities who were in the 1970s being moved into community settings with greater regularity. A fierce champion of individual rights and assimilation into the community, Wolfensberger's ideas resonated in Ontario with fellow advocates like Zarfas. Both supported care in the community but also recognised a need for new policies or practices for managing sexuality in this context.[19]

Zarfas' position revealed some of the edges of the debate in this period, as it straddled issues of personal autonomy, hygiene and parental authority. In spite of the stigmatising language, Zarfas vehemently advocated for the humanising of people who had long been institutionalised, which remained in line with the language of deinstitutionalisation that emphasised the need for people to be cared for in the community. That move, however, resurrected long-standing fears about people with disability or psychiatric illness in the community and the need to protect them from sexual predation. The underlying logic implied that people could not or would not engage in *protected* sex, and furthermore would be incapable of raising children. Moreover, children born to a parent or parents who were considered to have compromised mental functioning were disproportionately more likely to raise children incapable of reaching full independence through a combination of genetic and environmental influences. Among these influences, but rarely, if ever, mentioned explicitly, remained a firm conviction from policy-makers and reformers that those born into a life of poverty were unlikely to overcome this economic condition. Although the notion of responsible parenting might have been expanded to include other elements, the discussions centred on links between responsibility and welfare, or dependence on the state. Given that by the 1970s it was already clear that ex-psychiatric patients disproportionately lived below the poverty line, this connection took on additional meaning; poverty could be pathologised.

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[19] Wolf Wolfensberger, *The Principle of Normalization in Human Services* (Toronto: National Institute on Mental Retardation, 1972).

Eugenics and Institutions

In December 1978, headlines in the *Globe and Mail* informed readers that people with psychiatric or intellectual disabilities were continuing to be sterilised, and moreover, local Ontario support staff were encouraging these operations.[20] News of sexual sterilisations occurring in psychiatric or custodial institutions was reminiscent of eugenics and a history of coercive sterilisations, but while the surgical procedures remained consistent, the rationale had changed. Rena Paul, a social worker and former director of family services for the Metropolitan Toronto Association for the Mentally Retarded, said: 'sterilisation is the only method of birth control for mentally retarded people… I'm worried that a suspension of sterilisation will again lead to the segregation of mentally retarded men and women. These people should have the freedom to (have) sexual contact and to enjoy each other's company'.[21] The argument for sexual freedom added a significantly new dimension to the controversial debates that had long plagued discussions of sexuality and reproduction among institutionalised people. The language of sexual rights further complicated the idea that the law, and by extension medicine, had a responsibility to protect these so-called vulnerable citizens. These concerns raised in the *Globe and Mail*, therefore, tapped into a wider set of debates across the country as to how to balance the rights of disabled individuals with the internal and administrative function of institutions.[22]

By the end of the 1970s, the issue of sterilisation surgery for adolescent children with severe mental and physical disabilities attracted more publicity and became the focus of a review by the Law Commission of Canada aimed at providing legal guidance on the ethics of sterilisation. Among the variety of proposals it received from across Canada was one from Ontario health minister Dennis Timbrell, who suggested abolishing all sterilisations of minors and individuals with mental disabilities. Timbrell's proposal followed the release of a report from Dr. Donald Zarfas, by then a special consultant on mental retardation with the Ontario Ministry of Community and Social Services, indicating

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[20] *Globe and Mail* (14 December 1978), 1.

[21] Ibid.

[22] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, NY: Anchor Books, 1961).

that, in the absence of a clear policy on the matter, 608 individuals deemed mentally incompetent had been sterilised in 1976 without their consent, although the hospitals concerned had obtained consent from next of kin. Only fifty of the people sterilised were men or boys,[23] reinforcing a gender imbalance that has long persisted in sterilisation cases. Zarfas intervened by demanding that the CMPA provide guidance to physicians working with institutionalised populations. 'Doctors are entitled to know where they stand on the law. At the moment, there is a serious risk of actions for assault brought on by minors sterilised for non-therapeutic reasons once they reach their majority'.[24] At this point, the discussions continued to hinge on protecting the doctors from legal repercussions, more so than out of concern for the well-being or autonomy of individuals being subjected to sterilisation.

The CMPA stated emphatically that doctors should not initiate discussions about sterilisations, but rather should leave them up to the parents of patients to request such operations. In a sustained effort to avoid future legal challenges, the CMPA recommended a thorough set of assessments by a variety of medical professionals, including family physicians, psychologists, psychiatrists and, possibly, social workers to ensure that there was sufficient documented professional support for securing a decision about sterilisation that stood up to legal scrutiny.[25] Building upon past legal precedents, the CMPA added that the procedure should be explained to the child before proceeding, if all other parties are in agreement. This language, describing people as children further infantilised individuals who fell into this category, reinforcing the idea that they required protection from a paternalistic state with laws designed to make decisions on their behalf. Moreover, those decisions should rest on the shoulders of parents and not physicians, according to the CMPA.

The directions and guidelines stipulated by the CMPA reflected its familiarity with the challenges posed by the Alberta eugenics programme and its legacy in the 1970s, particularly for its lack of consent considerations, which ran roughshod over patients who had been deemed mentally incapable of providing consent: 'We are particularly concerned

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[23] "Sterilisation Ban Is Sought," *Calgary Herald*, 9 December 1979.

[24] Donald Zarfas, "Sterilisation of the Mentally Retarded," unpublished paper, 1978, Zarfas Papers, Centre for Addiction and Mental Health Archives.

[25] Letter from Dr. Norman Brown to Dr. Ian Burgess, 2 November 1978, 1.

about anything which might appear as an established program for "wholesale" sterilisations of these patients… We would be particularly concerned about the sterilisation of a child unless the operation were requested by interested, concerned and attentive parents'.[26] Whether responding to local sterilisation policy or international programmes that had garnered significant attention, the legal advice doled out to physicians by this time stressed the need for consent as a sacrosanct feature of modern medical interventions, but, in this case, consent from parents. Parents, according to the CMPA, could make informed decisions about their children's sexual and reproductive lives that struck a balance between individual rights and individual protection. These comments returned to older ideas of virtuous girls and women requiring protection from sexual predators, concerns that were amplified in the context of deinstitutionalised populations.

Disability, Dependent Adults and Institutionalised People

The Canadian Law Reform Commission concluded by the end of the 1970s that individuals with mental illnesses 'should not be sterilised against their will'. Indeed mentally handicapped persons 'should have the same rights as other persons to consent to or refuse sterilisation as long as they can understand the nature and consequences of the operation'.[27] Provinces, however, developed their own guidelines regarding sexual sterilisation and abortion operations for residents living in institutions. Alberta's Dependency Act introduced different approaches to informed consent by elevating third-party decision-makers and fundamentally triangulating the politics of choice as it concerned reproductive autonomy.[28] This assembly of decision-makers resembled the composition of eugenics boards, further elongating the tradition of a relationship between psychiatric and custodial institutions and eugenics. Working in direct contrast with the CMPA, the law commission instead looked to clinical professionals to make choices on behalf of institutionalised or

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[26] Ibid.

[27] As reported in "Protect Mentally Ill from Sterilization, Says Law Reform Commission," *Calgary Herald*, 9 December 1979, B3.

[28] Dyck, *Facing Eugenics*, 223.

recently deinstitutionalised patients of child-bearing age, although several of the people who had worked in the institutions now filled those positions in the community.[29]

Zarfas had defended the rights of individuals, but he emerged as a controversial figure in these debates, as he promoted sterilisation as a feature of (ex)patient liberty. In 1978, he addressed the Ontario Psychiatric Association and stated that 'in the 60s and coming together with the Civil Rights Movements throughout the world, has brought about the recognition of rights for retarded persons, whether they live at home, in community residences or in institutions. The recognition of their rights to an education, to treatment, to protection from abuse, to the due process of law, and, ultimately, to the right of life, has a tremendous effect on the retarded's place in society today. […] the retarded must be seen as individuals and not as a class of subhuman and inferior beings. We must give recognition to the retarded's right to self-determination within reason and his right to protection from abuse, even if we appear to be acting in his best interests'.[30] Walking a fine line between protection and restriction, Zarfas attempted to articulate the need to both humanise and protect this segment of the population, even as humanising meant accepting sexual relations as a normal feature of life. He later went on to insist that individuals had a right to sexuality and sexual expression, features that placed him within a liberalising agenda, yet, he identified sterilisation as a vehicle for achieving this liberty. In other words, Zarfas implied that people living in the community, with or without intellectual disabilities, should have access to the same reproductive and sexual health services, including sterilisation as a form of birth control. This suggestion positioned women considered mentally incompetent on equal footing with middle-class feminists who had lobbied for sterilisations as a form of birth control. As American historian Johanna Schoen has illustrated, however, the politics of race and ability routinely complicated this campaign for birth control. For white women with resources, a campaign revolved around the choice to have children, while for many other women, especially impoverished and racialised women, access to healthcare services was already lacking, and

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[29] Chris Dooley, "The End of the Asylum (Town): Community Responses to the Depopulation and Closure of the Saskatchewan Hospital, Weyburn," *Histoire Sociale* 44, no. 88 (2011): 331–54.

[30] Zarfas, "Sterilisation of the Mentally Retarded."

a long tradition of racist and sexist policies led many to distrust the medical establishment when it came to matters of reproductive health.[31] A similar narrative unfolded in Canada surrounding Indigenous women whose access to health service had languished behind those of their non-Indigenous counterparts. Faced with the decision to give birth in hospitals, and be sterilised, or remain at home without proper prenatal, antenatal, or contraceptive care presented women with very different contexts for exercising their so-called reproductive choices.[32]

The overlap between coercive eugenic sterilisations and sterilisation chosen for birth control continued to complicate the legality of the issue, walking a fine line between providing autonomy, as the notion of choice connoted, and exercising protection, in a more paternalistic sense. The latter reinvigorated eugenic approaches, or became part of the newgenic landscape. Zarfas commented on this point explicitly in a plea to the Ontario Medical Association: 'I am certainly not recommending legislation of a Eugenic nature. I am recommending, however, legislation that will provide the protection we have suggested so that incompetent people may have the right to enjoy the benefits of sterilisation as do myriads of their competent peers'.[33] Extending elements of protection from the state with the language of individual freedom, Zarfas borrowed from the discourse of social movements that helped to justify the need for continued professional surveillance over (ex)patients, who were implicitly women, making decisions about their reproductive lives. Disability activists, however, suggest that this sustained surveillance merely retained a eugenic approach, even while verbally denouncing it as a relic of past practices.

In one revealing paper on the sterilisation of 'mentally retarded females', Zarfas wrote: 'Let us immediately state that we are only dealing with the sterilisation of mentally retarded females, because, whatever her condition may be, there will always be a male ready to copulate and impregnate this defenseless being'. He added: 'it was never found difficult to decide that they should have an appendectomy or dental

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[31] Schoen, *Choice and Coercion*; Rickie Solinger, *Reproductive Politics: What Everyone Needs to Know* (Oxford: Oxford University Press, 2013).

[32] Erika Dyck and Maureen Lux, "Population Control in the 'Global North'?: Canada's Response to Aboriginal Reproductive Rights and Neo-Eugenics," *Canadian Historical Review* 97, no. 4 (2016): 481–512.

[33] Zarfas, "Sterilisation of the Mentally Retarded."

treatments. Since it is very obvious that they cannot take care of a child because they cannot even take care of themselves, the decision to sterilise them should not be so difficult unless fertility is still regarded in name as an unmitigated blessing for everybody, which it is definitely not'. He further explained that sterilisation is preferable to contraception, as it 'is run only once'.[34] Much like his contemporaries across Canada and the US working in the field of 'mental retardation', he emphasised the language of burden, irresponsibility and health risks associated with leaving these individuals unsterilised. In other words, the logical humanitarian response according to Zarfas, was to sterilise these women so that they could live freely and safely, without fear of becoming pregnant. Implicit in this discussion is an extension of rights-based logic to a group of people who were not extended the same rights and services that would allow for such a free choice in the first place. Moreover, many of the women he was describing continued to live in institutional or quasi-institutional settings. Despite efforts to embrace an ethos of care in the community, Zarfas and others working in the system quickly recognised that many of the people leaving institutions were not reuniting with loving families, but instead were shifting into half-way homes and other facilities where they may even be vulnerable to abuse, and certainly were not anointed with the kind of freedom of movement or independence afforded to most of mainstream society.

Personal vs. Mental Hygiene

Whether women in the community were taking advantage of their newfound sexual freedom or not is unclear, but within institutions, the concerns about fertility went beyond those associated with pregnancy. One of the focal points of this discussion rested upon matters of personal hygiene. In fact, one such case reached the Supreme Court of Canada, which involved a mother trying to have her daughter sterilised to alleviate her menstruation.[35]

Eve was a 24-year-old woman with 'extreme expressive aphasia' and limited learning abilities. During the weekdays, she was institutionalised

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[34] Ibid.

[35] Molly Ladd-Taylor, "Contraception or Eugenics? Sterilization and 'Mental Retardation' in the 1970s and 1980s," *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 3, no. 1 (2014): 189–211.

in a facility for people with 'mental disabilities' on Prince Edward Island and on the weekends, she lived with her mother, Mrs E. According to hospital administrators, Eve began developing an interest in one of the male residents, who was also described as disabled, and they informed her mother. Mrs E. felt that her daughter did not appreciate the concept of marriage and could not be responsible for raising a child, and ultimately, she requested that Eve be declared mentally incompetent under the provisions of the provincial Mental Health Act. Following that designation, Mrs E. suggested that she should be given the power of 'substitute decision maker', and then she could recommend that Eve be sterilised for non-therapeutic reasons. The case bounced through the court system, beginning in a provincial family court and ultimately landing in the Supreme Court of Canada, where the country's highest judicial power ruled against her mother's request and set a new precedent in the country for denying the role of third-party or substitute decision-makers in sterilisation cases for people considered mentally incompetent.

The timing of the *Eve* case was significant. Its decision in 1986 came shortly after the introduction of Canada's Charter of Human Rights and Freedoms (1982), and the decision also preceded some of the other common law jurisdictions who were similarly struggling to find the legal balance between *parens patriae* and individual rights. In many cases, states were also reconciling the legacy of eugenics, which further complicated discussions about who could make decisions on behalf of people considered mentally incompetent. This point was made even more significant in an era of deinstitutionalisation or psychiatric care in the community, as the dynamic concepts of prevention, protection and individual rights were being re-evaluated and redefined.[36]

Eve's case was not an isolated incident, but instead widened the public discourse on this topic. In Calgary, a hospital administrator at the Grace Hospital explained that he had experienced three recent cases of minors who were considered incompetent, incapable of controlling their bodily

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[36] For more examples that challenge these boundaries, see eugenicsarchive.ca/discover/our-stories, accessed 20 January 2018. Some of the contemporary examples in this collection reveal the ways that elements of newgenics continue to frame ideas about capable parenthood, as well as the notion that restricting these people from parenting serves to prevent mental disorder and dependence. In particular, see stories by: Candace, Eric, and Velvet.

functions, and 'unable to look after their personal hygiene'.[37] The parents in each of these three cases had requested hysterectomies for their daughters when they reached puberty, due to the challenges dealing with their menses.

Zarfas agreed with the logic behind this procedure even while disagreeing with the right of parents to initiate the requests. He argued: 'Where hysterectomy is contemplated for control of menstruation in a seriously-retarded person, all measures to train the child in management of menstrual discharge by competent professional trainers have been unsuccessful, and oral or parenteral contraceptive steroids are either unsuccessful or not tolerated'. Lest his concern for autonomy be unclear, he went on to state: 'It would be possible for an emancipated, retarded youth to give consent; however, one must be certain that this patient knows the nature and consequence of the surgery. One should also be assured that external coercion is not forcing the decision'. [38]

His views on parents were informed by a survey he conducted with parents of children with disabilities and birth control in southwestern Ontario. He contacted 300 parents in Essex, Middlesex and Waterloo to gauge their reactions to birth control for their disabled children, shifting the focus away from mental disorders or intellectual disabilities, to questions of hygiene for individuals who were physically disabled. In his preliminary report, he showed that parents overwhelmingly supported sterilisation over other forms of birth control, including (a) no birth control (12%); or (b) contraceptives including the pill, intrauterine device, condom, or injectionable long-acting birth control (16%). By comparison, 67% preferred sterilisation in the form of tubal ligations, vasectomies or hysterectomies. In spite of these views, only 7% of the parents interviewed had sterilised their children, while 69% relied on supervision from a combination of parents and professionals.[39] The discrepancy in the numbers suggests that parents were keen to have their children sterilised, but encountered difficulties in procuring the services. Zarfas' study revealed that regardless of the sex of the child, parents sought and even

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[37] Letter from David Luginbuhl to Lieutenant-Colonel Routly, Women's Social Services Secretary, Salvation Army Headquarters, 16 May 1983, 1–2, GRA-011, Calgary Health Services Archives.

[38] Zarfas, "Sterilisation of the Mentally Retarded."

[39] Ibid.

anticipated involuntary sterilisation as a necessary part of their care plan, and indeed as a consequence of care in the community.

Zarfas's actions suggest that a return to the community involved a return to parental control for most of the individuals who had been living in custodial institutions. Given that the parents he surveyed held strong views in favour of sterilisation, a return to the community did not mean relinquishing the institutional control over one's body, but rather it formalised the triangular decision-making over children's and dependent adults' reproductive bodies, retaining rather than removing the impulse to prevent procreation for people considered mentally or physically dependent, and thus, incapable of producing independent and healthy children.

Conclusion

It was not until 1982 with the introduction of the Charter of Rights & Freedoms that individual choice became more formally enshrined in the legal landscape. The 1970s, therefore, remained murky legal territory for teasing apart the relationship between the state and the individual in contests over who decides whether one is capable of responsible parenthood, and how that debate trickles down to regulate sexuality. The debates over reproductive health and access to its services remained pregnant with protectionist discourse when it came to people considered physically disabled, mentally ill, or intellectually delayed. Not all reproductive bodies laid claim to the same degree of equal citizenship rights in practice; yet, the language of rights continued to frame debates over how best to accommodate all Canadians.

In 1986, the Supreme Court's decision on Eve drew a decisive line in the sand on these debates. The ruling revealed that despite any of the past justifications for seeking non-consensual sterilisation, whether preventing pregnancy, reducing long-term care costs or controlling menstruation, neither the state nor families had a role to play in recommending this surgery. The legal reports that followed spelled out a new era for sterilisation in the mental health arena:

> With *Eve*, the ground rules have completely changed. Concern about the potential for unwarranted sterilisation of vulnerable individuals has been replaced by concerns about a situation in which those not competent to legally give their consent are barred from access to this form of birth control or menstrual management.

> The message ‘we will not let you risk having babies’ of the eugenic sterilisation days has changed to the message ‘we insist that you risk having babies.’[40]

This decision represented a significant shift from preventing people considered mentally incompetent from reproducing, to preventing an abuse of power over these people, by denying sterilisation surgeries for all people declared incompetent under mental health laws. Questions of mental health and competency continued to function like a hinge in these decisions, swinging the door open to sterilisation for nearly half a century, then swinging it in the other direction as a declaration of mental incompetency became a reason for restricting sterilisation under any circumstances. These decisions run precisely opposite to the rationale used for so-called healthy or competent members of society, who were denied access to contraception until 1969, then increasingly embraced it as a feature of modern human rights discourse. By 1988, the Canadian figures matched those of other Western countries, showing that sterilisation operations had replaced the birth control pill as the leading means of contraception for men and women considered healthy and competent, representing nearly 70% of women using contraceptives; men choosing vasectomy followed several years later.[41] For those men and women considered unhealthy and/or incompetent, access to sterilisations and in some cases safe sexual practices, continued to invite scrutiny and judgement, occasioning public debate rather than private choices.

As major custodial institutions had opened their doors in the 1960s and 1970s, this practice ushered in an era of deinstitutionalisation, and the idea of reintegrating these people into communities gave reformers pause. Patients’ rights movements merged comfortably with other human rights rhetoric that embraced the language of liberty and autonomy as a basic tenet of individual rights, but the discourse did not fit as comfortably as the practice.[42] Patients and ex-patients continued to be

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[40] Institute of Law Research and Reform, Edmonton, Alberta, *Sterilization Decisions: Minors and Mentally Incompetent Adults*, Report for Discussion No. 6, March 1988, 2.

[41] Ibid., 1. Rebecca Kluchin found that by 1975 sterilisation was the most popular form of birth control used by married couples in the United States, with 7.9 million operations performed only 2 years after the law changed permitting such surgeries. See Kluchin, *Fit to Be Tied*, 1.

[42] Nancy Tomes, “The Patient as a Policy Factor: A Historical Case Study of the Consumer/Survivor Movement in Mental Health,” *Health Affairs* 25, no. 3 (January 2006): 720–29.

targeted for sterilisation in the 1970s, while the legal parameters were furnished with new justifications to uphold this longer tradition. Mental hygiene movements of the 1920s relied on language of hygiene to refer to the pressing need to rid society of allegedly undesirable citizens, those who due to heredity, character, or lowered intelligence threatened to destabilise progress. Half a century later, the language was updated to suit the culture of rights that permeated the 1960s and 1970s, but the underlying assumptions about preventing disorder and disability remained in tact. By the end of the 1970s, personal hygiene replaced mental hygiene as a reason for sterilisation. The focus also shifted back to women as those most in need of hygienic intervention and fertility control. It remains unclear as to whether the women themselves appreciated the shift in justification, but the results remained fixed: sterilisation for these women continued, and even became part of the landscape of care in the community. The shift was replete with a human rights agenda suggesting that controlling reproduction within the population contributed to a reduction in the number of people suffering from psychiatric and intellectual disorders.

CHAPTER 12

Preventing Male Mental Illness in Post-war Britain

Ali Haggett

INTRODUCTION

Writing in 1960, Alfred Torrie, consultant psychiatrist and former superintendent of the Retreat at York, observed that many books had been written about the problems of children and old people; however, little guidance was available to middle-aged men with personal problems. Having identified this lacuna in health advice literature, he noted that there were a number of reasons for such inattention:

> The middle-aged man is expected to have reached maturity; to be in the prime of life; to have passed the problems of adaptation to adulthood; to have become settled; to have become a husband and a father; and to be respected in the community as a leader, looked up to by his fellows.[1]

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[1] Alfred Torrie, *The Middle Aged Man: The Way of Understanding* (London: The Church of England Moral Welfare Council, 1960), 2. Torrie was medical director of the National Association for Mental Health after the Second World War, and was also associated with the Tavistock Clinic, the Child Guidance Movement and the National Marriage Guidance Council.

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It was understandable, therefore, that 'he is passed by as someone who is perfectly able to manage himself and his affairs'. In his advice pamphlet, Torrie went on to warn that men were not always so invincible, but in fact, they could be prone to a host of 'stress diseases' such as: gastric ulcers, coronary heart disease, high blood pressure and other intestinal disorders. Because these conditions were 'physical' in presentation, he warned 'the fact that the middle age man is unhappy and suffering from emotional disability is often passed by'. Touching on a number of important challenges of 'middle age', he drew attention to the fact that men might increasingly become prone to hypochondriacal illness, weight gain and anxiety about the loss of looks and sexual potency. Disappointment and depression were the likely result, according to Torrie, when men attempted to 'hitch [their] wagon to a star in middle age'.[2]

Not only was this pamphlet indeed one of a very small number of publications aimed specifically at men's health and well-being, it is questionable how widely it was read—or how useful it was, given that Torrie's recommendations were that, for such men, the ultimate solution was spiritual, involving nothing less than complete commitment to God.[3] The lack of preventive health information available to men in the decades following the Second World War is the focus of this chapter. As a number of scholars have begun to show, men's psychological problems have historically been less visible, perhaps because it has more usually been the male 'gaze' that has observed and examined—the male norm being that by which others have been measured.[4] In part, as a result of the enduring cultural association between women and irrationality, many assumptions have been made about gender and health through the decades. In previous work, I have shown how male distress has tended to

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[2] Ibid., 2, 5. For a history of stress, see Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013).

[3] Torrie, *The Middle Aged Man*, 15.

[4] Ali Haggett, *A History of Male Psychological Disorders in Britain, 1945–1980* (Basingstoke: Palgrave Macmillan, 2015), 18. See also Mark Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, MA: Harvard University Press, 2008), 281; and Steve Robertson and Robert Williams, "Men, Public Health and Health Promotion: Towards a Critically Structural and Embodied Understanding," in *Men, Masculinities and Health*, eds. Brendan Gough and Steve Roberson (Basingstoke: Palgrave Macmillan, 2009), 61.

present 'atypically', in ways that do not fit comfortably within the current clinical paradigm for mental illness.[5] It is also now increasingly accepted that men are less likely to recognise poor psychological health, and reluctant to seek medical help when they do.[6] As Torrie noted pertinently in 1960, many men were terrified of consulting the medical profession for help, in fear that they might be told their unhappiness was due to mental disorder.[7] This chapter seeks to extend the boundaries of previous work, to explore the discourse around gender and prevention of mental illness in Britain from the 1950s. How was important information about health and well-being communicated to men? What were contemporary concerns about psychological health? How did men conceptualise good mental health, and to what extent was there demand for preventive information? Drawing on a range of printed primary material, archival material from the National Association for Mental Health (NAMH/MIND) and studies of health information and lay medicine, the chapter will explore the medical, political and cultural context within which men and women negotiated ideas about their own well-being. It will argue that, for a range of complex reasons and competing exigencies, male mental health was almost entirely neglected—both reflecting and reinforcing prevailing assumptions about masculinity, coping and the image of the 'strong, silent man'.

New Anxieties, and Communicating Health in Post-war Britain

It is now well documented that during the twentieth century, the West witnessed a decline in infectious disease and a rise in what has variously been described as 'chronic' diseases such as cardiovascular disease, cancer and diabetes. Historians have viewed this epidemiological transition in different ways and cautioned that chronic illness has a long history

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[5] Haggett, *A History of Male Psychological Disorders*, Chapter 1.

[6] See, for example, Anne Cleary, "Suicidal Action, Emotional Expression and the Performance of Masculinities," *Social Science and Medicine* 74 (2012): 498–505; David Wilkins, *Untold Problems: A Review of the Essential Issues in the Mental Health of Men and Boys* (London: Men's Health Forum, 2010); Roger Kingerlee, Duncan Precious, Luke Sullivan, and John Barry, "Engaging with the Emotional Lives of Men," *The Psychologist* 27, no. 6 (2014): 418–21.

[7] Torrie, *The Middle Aged Man*, 10.

that precedes the twentieth century.[8] David Armstrong suggests that the statistics do not reflect a simple biological reality, but in fact illustrate how medicine began to reconfigure the natural ageing process of decay and degeneration, to a pathological process to be diagnosed and treated.[9] Nevertheless, it is certainly the case that during the 1960s, concerns were raised about conditions, which could conceivably be 'preventable' if lifestyles were moderated or changed. The importance of prevention and the role of social factors in disease were at the heart of theories put forward by the social medicine movement in Britain, which, although it remained peripheral to clinical medicine, nonetheless attempted to bridge the divide between prevention and cure.[10] Not only did the apparent rise in numbers of non-communicable diseases cause clinical concerns, but the fiscal pressures of health and welfare provision prompted urgent debates about public health policy—with particular reference to smoking, diet and alcohol consumption. As Virginia Berridge has noted in her extensive work on public health policy, concerns about smoking and lung cancer during the 1950s marked the change of emphasis from acute infectious to chronic disease 'and the beginnings of a new lifestyle-oriented, activist, single-issue public health, which came to fruition in the 1970s'.[11] Increasingly, in this new era of public health, the government assumed responsibility for advising the public on health matters, by utilising the most up-to-date mass media. At the heart of these developments was the concept of population level, 'risk-factor' medicine, associated strongly with the Scottish epidemiologist Jerry Morris, who argued that 'individuals had considerable influence over their own health and needed to utilise self-reliance and self-control'.[12]

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[8] See Carsten Timmermann, "Chronic Illness and Disease History," in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (Oxford: Oxford University Press, 2011), 2, https://doi.org/10.1093/oxfordhb/9780199546497.013.0022.

[9] David Armstrong, "Chronic Illness: A Revisionist Account," *Sociology of Health and Illness* 36, no. 1 (2014): 15–27.

[10] Dorothy Porter, "Introduction," in *Changing Disciplines*, ed. John A. Ryle (New Brunswick, NJ: Transaction, 1994 edition), xxxi. See also George Weisz, *Chronic Disease in the Twentieth Century: A History* (Baltimore: John Hopkins University Press, 2014).

[11] Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford: Oxford University Press, 2007), 2.

[12] Weisz, *Chronic Disease*, 191. See also Virginia Berridge, "Smoking and the New Health Education in Britain, 1950s–1970s," *American Journal of Public Health* 95, no. 6 (2005): 956–63.

For a number of reasons, however, communicating these new concerns to the public was not straightforward. In the 1950s, the medical profession was subject to established ethical conventions, which prevented advertising and discouraged contact with the media. Clinicians, more broadly, were also notoriously suspicious of media publicity.[13] As numerous historians have noted, a culture of secrecy surrounded the medical profession—deference and moral authority provided a means by which they distanced themselves from quacks who advertised patent medicines as consumer goods.[14] One consequence of this was that patients knew very little about their illnesses. As Alex Mold has shown, 'a culture of paternalism existed within the medical profession, perpetuating the view that "the doctor knows best" and patients should accept a largely passive role'.[15] Doctors believed that informed patients were dangerous and that media coverage of medical issues would result in anxiety and hypochondria.[16] The limited range of broadcast material on BBC radio was, as Ayesha Nathoo notes, paternalistic, with 'the BBC prescribing the types of programmes listeners should hear, and doctors entrusted with deciding what was best for their patients'.[17] However, during the 1960s, this situation began to change, heralded by the growth of post-war social surveys and the emergence of early patient advocacy groups, which demonstrated that patients wanted more information about health and disease.[18]

The government agency central to health information during the late 1960s was the Health Education Council (HEC), set up in 1968 and reformed in 1973.[19] The Royal College of Physicians' 1962 report

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[13] Kelly Loughlin, "Networks of Mass Communication: Reporting Science, Health and Medicine in the 1950s and 1960s," in *Making Health Policy: Networks in Research and Policy After 1945*, ed. Virginia Berridge (Amsterdam and New York: Rodopi, 2005), 303–4.

[14] Virginia Berridge, "Smoking and the Sea Change in Public Health, 1945–2007," Policy Paper, *History and Policy*, 4 June 2007.

[15] Alex Mold, *Making the Patient Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester University Press, 2015), 18.

[16] Anne Karpf, *Doctoring the Media: The Reporting of Health and Medicine* (London: Routledge, 1988), 4.

[17] Ayesha Nathoo, *Hearts Exposed: Transplants and the Media in 1960s Britain* (Basingstoke: Palgrave Macmillan, 2009), 37.

[18] See Mold, *Making the Patient*, Chapter 1.

[19] Berridge, "Smoking and the Sea Change." Prior to the Second World War, the ministry supported voluntary organisations, such as the Central Council for Health Education, but moved to centralise services during the War to deal with national exigencies.

on smoking and the 1964 report of the Cohen committee on health education highlighted the need for central publicity on health issues, promoting a 'new breed' of educators, trained in journalism and behavioural sciences.[20] Through the 1970s, the HEC employed advertising agencies to produce posters, brochures and newspaper adverts highlighting the dangers of smoking.[21] From the 1950s, the Central Office of Information (COI), which was formed after the War and the closure of the Ministry of Information, continued a much longer history of transmitting public information films on aspects of public safety and health.[22] Concurrently, as other historians have noted, television broadcasting began to cover medical topics, both fictionally and in documentary style. ITV's *Emergency Ward 10* (1957) and the BBC's pioneering series, *Your Life in their Hands* (1959) both attracted large audiences. Despite continued tensions about the dangers of well-informed patients, both were generally well received.[23] It is within this context that this chapter will turn next to explore the ways in which shifting patterns of disease and new models of communication impacted upon preventive health information directed at men.

Lay Medicine and Discourses of Health

From the rich archive of public information films produced by the COI, material on psychological well-being—and most specifically advice directed to men—is notable by its absence. From post-war austerity to Thatcher's privatisation during the 1980s, themes reflected the social, cultural, political and scientific context of the time. Similarly, medical topics reflected anxieties about health-related exigencies. In the immediate post-war period, films emphasised the importance of preventing the spread of cold and cough viruses. The dangers of drink driving were highlighted during the 1960s, and the risks associated with smoking

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[20] Ibid.

[21] Ibid., 960–61.

[22] See Timothy Boon, "Films and the Contestation of Public Health in Interwar Britain" (Ph.D. diss., University of London, 1999).

[23] See Michael Essex-Lopresti, "Your Life in Their Hands," *Lancet* 368 (2006), s24–s25; Kelly Loughlin, "'Your Life in Their Hands': The Context of a Medical-Media Controversy," *Media History* 6, no. 2 (2000): 177–88; and Nathoo, *Hearts Exposed*, 46.

during the 1970s.[24] Many of the public information films focused on safety risks associated with the failure to wear car safety belts, irresponsible use of fireworks and the dangers of railway tracks and electric power stations.[25] The government response to the emergence of the AIDS virus is now well documented, and roundly portrayed in the 1980s media campaign, chillingly entitled ‘Don’t die of Ignorance’.

Although topics appeared to circumvent themes on psychological well-being, one darkly comedic film, entitled *What a Life*, released by the COI in 1949, perhaps gave some insight into the pressures of being a man in post-war Britain. The film featured two businessmen, worn down by austerity, who together, attempt to end their lives by drowning. Their suicide plots fail, and the film ends with the men returning to the bar for last orders, laughing uncontrollably at their plight. The film was attacked in the House of Commons for its doom-mongering. A Conservative MP wanted to know if it had been an appropriate way to spend £9000 of taxpayers’ money.[26] It is perhaps ironic that the film explicitly embraced the theme of male misery and distress; yet, government information campaigns never fully pursued this topic, nor implemented preventive strategies to foster positive mental health and well-being.

Not only did campaigns focus on a set of medical priorities, mostly unrelated to psychological health, in many cases, they highlighted health risks to women and not to men. As Berridge has noted, during the late 1950s, when the connection between smoking and lung cancer became clear, the medical profession and the Ministry of Health had major anxieties about directing health education towards men, who were the largest group of smokers at that time. Women re-emerged in the 1970s in anti-smoking campaigns as mothers, with the smoking problem defined in accordance with their reproductive role—although the ‘at-risk’ foetus in adverts was usually portrayed as male.[27] Unsurprisingly, concerns about the overuse of alcohol also reflected long-established moralistic overtones about women and alcohol, despite

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[24] Berridge, “Smoking and the New Health Education,” 959.

[25] Films available at http://www.nationalarchives.gov.uk/films/.

[26] See BFI Screenonline, http://www.screenonline.org.uk/film/id/1120964/index.html, last accessed 11 February 2018.

[27] Berridge, “Smoking and the New Health Education,” 961–62.

the fact that drinking alcohol has been one of the most common ways in which men have self-medicated for distress—and alcohol-related morbidity/mortality has historically been much greater in men. As historians have shown, the focus has commonly been ‘not so much on women as women, but on women as mothers, and on the notion of maternal neglect’.[28] Information available to the public was also often ‘female-focused’. A literature review of health information published as recently as 1994 found many studies on specific conditions that affect women, such as the menopause. Other research focused upon ‘women’s preferences’ in relation to other diseases.[29] Elaine Kempson, who published a well-cited review of consumer health information in 1987, held discussion groups with people ‘likely to have needed health information in the recent past’. Notably, among this group were ‘wives of men recovering from surgery’. Implicit in the design of the study, therefore, was the assumption that women were more likely than men to seek health information. Local studies appeared to support this contention, and Kempson noted that ‘women, traditionally, bear the responsibility for the health and care, not only of their children, but also of sick and elderly relatives’.[30]

In 1973, C.P. Elliot Binns, a general practitioner from Northampton, published a paper in the *Journal of the Royal College of General Practitioners,* which gave some insight into the social and cultural factors around advice-seeking behaviour. Based on a survey of his patients, Elliot Binns confirmed that ‘in the past, medical care has been the prerogative of women, and it apparently still is’. Male relatives, he noted, when

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[28] Peter Borsay, “Binge Drinking and Moral Panics, Historical Parallels?,” *History and Policy*, http://www.historyandpolicy.org/policy-papers/papers/binge-drinking-and-moral-panics-historical-parallels, last accessed 20 April 2018. See also Virginia Berridge, Rachel Herring, and Betsy Thom, “Binge-Drinking: A Confused Concept and Its Contemporary History,” *Social History of Medicine* 22, no. 3 (2009): 597–607.

[29] Sarah Buckland, “Unmet Needs for Health Information: A Literature Review,” *Health Libraries Review* 11 (1994): 82–95 (84 and 86).

[30] Elaine Kempson, *Informing Health Consumers: A Review of Health Information, Needs and Services* (London: College of Health, British Library, 1987), 6 and 50. For a historical perspective on women as medical consumers, see Ali Haggett, *Desperate Housewives, Neuroses and the Domestic Environment, 1945–1970* (London: Pickering and Chatto, 2012), 153; and Nancy Tomes, “Skeletons in the Medicine Closet: Women and ‘Rational Consumption’ in the Inter-war American Home,” in *Health and the Modern Home*, ed. Mark Jackson (New York: Routledge, 2007), 177–95.

approached to give medical advice, tended simply ‘to suggest a visit to the doctor’, and it was ‘most unusual for a male patient to receive advice from someone of his own sex’. Typifying the attitude of many male patients, Elliot Binns described the case of a middle-aged man, recently widowed, who came to his surgery complaining of backache. The man had ‘consulted no one, because he had no friends’ and had bemoaned: ‘anyway, if I got some ointment, there’s no one to rub it in’. The survey suggested that, although a doctor’s advice was considered to be the most reliable, impersonal sources of medical information were increasingly important. Women’s magazines, ‘home doctor books’ and the use of home remedies illustrated that home medical care played an essential role.[31] A repeat survey, published in 1986, found very little change, except that pharmacists and the television emerged as increasingly popular sources of information.[32] A 1960 study of medicine consumption suggested that, from adolescence, pharmacological consumption began to decline in boys, but rose in girls. The rise continued significantly, until after age forty-five, when the gap between the proportion of men and women taking medicines—both prescribed and otherwise—began to narrow. The study also found that women took more laxatives and aspirin than men, and further that smaller families, who had higher levels of education, were more likely to be prescribed medication.[33]

If home doctor books and media advice were popular, they merely served to reinforce the assumption that women should be responsible for home health—and that men did not need instruction in such things. It is difficult to gauge which books were consulted most frequently since specific titles did not appear in surveys. However, one notable publication, authored by Kenneth C. Hutchin, a former Major in the Royal Army Medical Corps and general practitioner in Hatfield, deserves special attention. The book, entitled *How Not to Kill Your Husband*, published in 1962, was widely circulated and translated into six foreign languages. Hutchin, who authored the series anonymously as ‘A Family Doctor’,

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[31] C.P. Elliot Binns, “An Analysis of Lay Medicine,” *Journal of the Royal College of General Practitioners* 23 (1973): 255–64 (258, 262 and 264).

[32] C.P. Elliot Binns, “An Analysis of Lay Medicine: Fifteen Years Later,” *Journal of the Royal College of General Practitioners* 36 (1986): 542–44.

[33] Margot Jefferys, J.H.F. Brotherston, and Ann Cartwright, “Consumption of Medicines on a Working Class Housing Estate,” *British Journal of Preventive and Social Medicine* 14, no. 2 (1960): 64–76.

appeared to agree with Alfred Torrie, that men were more vulnerable than most would assume. Chapter 1 of his book opened unequivocally: ‘That many men manage to survive the forties is largely a matter of luck. Very few men could claim any credit for this achievement’. Expanding further, Hutchin confirmed that his book was explicitly ‘addressed to women’, since, ‘when it comes to looking after their health, many men are complete imbeciles. The lucky ones are the ones who have wives who will do it for them’. Acknowledging that some men might find such attention stifling and feel as though they were ‘tied to their wives’ apron strings’, he cautioned that ‘it is better to live a long time at the end of your wife’s apron strings, than to be completely free, and dead’.[34] The book proceeds to explore a wide range of physical conditions, with particular focus on the heart, the arteries and coronary thrombosis—but notably with nothing dedicated directly to psychological well-being. Hutchin did observe that some men were prone to what he described as ‘gastric neurosis’, caused by stress and often by over-consumption of medicines from the bathroom cupboard. Gastric pain, he noted, was more likely to be in the mind than the stomach. Advising the reader that wives should take their husbands for a holiday to the sea, taking all the medicines in the bathroom cupboard with them in an old suitcase: ‘When they arrive, they can go down to the end of the pier and drop the whole thing into the sea’.[35] The author did concede that prevention was better than cure and that ‘over stress, over smoking, over eating, over working and over drinking’ were excesses that might result in a major calamity such as a coronary thrombosis.[36] Nevertheless, the overall message from Hutchin merely reinforced the stereotypical view of the strong, silent man. Stating that it was ‘better’ for a wife to take control of the situation, he noted that ‘the man who fusses about his health can never be normal, because it is not normal for a man to fuss about his health’.[37] Hutchin ended his book with a word of caution to women. In addition to keeping a watchful eye over her husband’s health, she should also remain ‘fun’ and ensure that her personality remain a source of attraction for him: ‘The wife who allows her husband to live it up

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[34] A Family Doctor, *How Not to Kill Your Husband* (London: George Allen and Unwin Ltd, 1962), 11–12.

[35] Ibid., 171.

[36] Ibid., 96.

[37] Ibid., 13.

with his secretary or some model, is failing in her duty to him. It is not only a wife's duty to keep her husband alive, it is her duty to keep him'. Marriage could potentially be lethal, he warned, since 'wifing a husband is often far more effective than knifing him'.[38]

Hutchin went on to publish numerous other medical texts on a range of topics such as coughs, colds, hypertension and allergy. Presumably, testament to its success, the 'family doctor' series continued over the next decade with the titles: *How Not to Kill Your Wife* (1965), *How Not to Kill Your Children* (1968) and *How Not to Kill Yourself* (1973). Hutchin's text on wives, opens with a chapter entitled, 'Don't Kill your Goose', and the caveat: 'In writing this book, I realise that it will not have the same popular appeal as *How Not to Kill Your Husband*, for men have not the same vested interest in keeping their wives alive'.[39] Through a series of chapters on such topics as calories, cigarettes and the 'sexwife' (in which men were reminded that sex in marriage was not *only* for their gratification), the book attempts to rebalance spousal responsibility for the family's health. Men are even reminded that wives should not be the 'family doormat'. However, it falls spectacularly into gendered assumptions about propensity towards specific diseases. Unsurprisingly, whole chapters are dedicated to hormones, menstruation and the menopause. Husbands are reminded that menstruation and the premenstrual period take up more than a quarter of a woman's life and therefore, 'the subject dominates your wife's thoughts'. However, Hutchin warns that 'it is a mistake to use any expression which implies that menstruation is an illness or a hardship – or any word which could make a girl feel sorry for herself'.[40] More striking is the fact that an entire chapter is dedicated to anxiety and psychological difficulties, a topic that was notably absent from his book on men. Reminding husbands that if sympathetic assurance or astringent firmness failed, severe cases might need to be attended to by an expert psychiatrist. The book closes leaving the reader in no doubt that a wife should be loved and cherished, but that women were more naturally fitted to caring for others—and at the same time predisposed to hormonal and psychological difficulties.

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[38] Ibid., 216 and 223.

[39] A Family Doctor, *How Not to Kill Your Wife* (London: George Allen and Unwin, 1965), 9.

[40] Ibid., 29 and 33.

Writing again just a year later (this time under his real name), in a book entitled *The Health of the Businessman*, Hutchin dedicated a whole chapter to 'stress'. Replete with references to the working day, business life and coronary thrombosis, the material still provided little by way of helpful advice about psychological health. Preventive advice was limited to suggestions that the businessman should delegate more and avoid frustration. Indeed, should stress produce psychological or psychosomatic symptoms, guidance weighed heavily towards medical intervention. If stress reached acute levels minor tranquillisers—particularly those combined with antispasmodics and analgesics—were recommended for muscular and mental relaxation.[41] As I have shown elsewhere, these 'combi-drugs' were widely prescribed to men through the 1960s and 1970s, but did not appear in statistics for gender and psychotropic drug prescriptions, in part distorting the degree to which women appeared more likely to receive psychotropic therapy.[42]

As medical topics increasingly gained exposure during the 1960s, 'control' over what topics were covered became ever more important. As Nathoo notes, 'the [medical] profession aimed to retain a low profile but a high status'.[43] Nevertheless, the public increasingly desired more information about health and medicine. Men and women, for example, sought medical advice from agony columns in newspapers and magazines. Throughout the 1960s and 1970s, columns emerged in most of the well-read publications, and by the early 1980s, the well-known agony aunt Claire Rayner received 1000 letters a week, in addition to the audience reached via other work in broadcast television and radio.[44] Richard Smith, then editor of the *British Medical Journal*, writing in 1983, noted that problem pages reached huge audiences in waiting rooms around the country. Medical advisor himself to a magazine, he observed that 'letters come from anxious women, whose cantankerous old fathers refuse to see a doctor […] Letters do come from men, but I've never seen a letter from a man worried about his mother, wife or daughter, who would not see a doctor'. Letters to problem pages suggested that the public usually

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[41] Kenneth C. Hutchin, *The Health of the Businessman* (London: Business Publications, 1966), 285.

[42] See Haggett, *A History of Male Psychological Disorders*, Chapter 4.

[43] Nathoo, *Hearts Exposed*, 42.

[44] Richard Smith, "Part Time Agony Aunt in Trousers," *British Medical Journal*, 8 October 1983, 1029–31.

fell into two camps: those who had sought medical advice already, and those who had not—the latter being the most worrying. Often, people felt that they had received the 'wrong' advice; some claimed that they were victims of negligence, and others felt that their doctor was not interested in their problems.[45] Despite this, general practice surveys of the time suggested that the public were broadly satisfied with primary care, but increasingly demanded more information.[46]

Alex Mold has shown in detail how, through the 1960s and 1970s, growing importance was attached to patient autonomy and consumerism in health care. A number of drivers were central to this—of note was the emergence of bioethics and notion of 'informed consent'. Within this context, patient advocacy groups began to emerge such as the Patients Association (1963), and later, the College of Health (1983).[47] Given that patients' autonomy moved gradually away from a situation in which the medical profession had previously wielded such control, it is perhaps not surprising that patients' desire for information focused initially on medical exigencies—aspects of health and disease that were viewed as priority. Kempson, in a literature review of previous research, illustrated that patients wanted information about: specific illnesses; impending medical treatment; diagnostic tests, drugs and their side effects.[48] Preventive advice—particularly that on mental health—did not feature strongly in the literature. Sarah Buckland's later study, published in 1994, stated specifically that all research had focused broadly on 'disease and coping' information. Patients' knowledge of health-related issues was still 'poor' and there was a lack of knowledge about where to seek information.[49]

Research indicated that there were a number of barriers to obtaining health information. Where patients consulted the family doctor, communication problems often arose during the consultation.[50] A number of studies suggested that working-class patients tended to be diffident asking questions. Hence, those who had received a higher level of education

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[45] Ibid., 1030.

[46] See Ann Cartwright, *Patients and Their Doctors: A Study of General Practice* (London: Routledge and Kegan Paul, 1967); and Mold, *Making the Patient Consumer*, 18.

[47] See Mold, *Making the Patient Consumer*, Chapters 1 and 5.

[48] Kempson, *Informing Health Consumers*, 19 and 52.

[49] Buckland, "Unmet Needs for Health Information," 86.

[50] For a history of communication in general practice, see Haggett, *A History of Male Psychological Disorders*, Chapter 1.

and were more assertive in their approach received more information.[51] Specifically, patients who were more emotionally expressive received more information. Men were notoriously poor at showing their emotions, in particular with regard to seeking medical advice.[52] As recently as the 1980s, scholars from the social sciences argued that physicians' 'need for power' continued to influence their practice when giving information. This was exacerbated if patients had only known their physician for a short time.[53] Elliot Binn's 1973 study of lay medicine demonstrated that patients felt advice on psychiatric illness was poor in comparison to that on physical illness. Further, he found that those with psychiatric disorders often postponed a visit to the doctor. Informal sources of advice were often untrustworthy, sometimes causing unwarranted or excessive anxiety—and nurses, perhaps surprisingly, scored particularly high when it came to 'frightening the patient'. Home doctor books were often kept long after they were out of date. One respondent claimed to have used a work by Aristotle, which had apparently been 'instrumental in saving five lives'. Even recent books, cautioned Binns, might be misleading.[54] Although, as Mold illustrates, by the 1980s, health-related topics were frequently covered in magazines such as *Which*, surveys suggested that the public was still poorly informed.[55] Medical books in public libraries were frequently out of date and doctors expressed concern that articles in newspapers and magazines left people 'half informed'.[56] By the late 1980s, the Consumer Association and the associated Which? Group had begun to produce information on health topics that aligned with a preventive approach; Mold notes that the audience for such material was not inconsiderable.[57] However, given the long-standing trend in which

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[51] Howard Waitzkin, "Information Giving in Medical Care," *Journal of Health and Social Behavior* 26, no. 2 (1985): 81–101 and 83; and Richard L. Street Jr., "Information Giving in Medical Consultations: The Influence of Patients' Communicative Styles and Personal Characteristics," *Social Science and Medicine* 32, no. 5 (1991): 541–48 (541).

[52] See Haggett, *A History of Male Psychological Disorders.*

[53] Waitzkin, "Information Giving," 84.

[54] Elliot Binns, "An Analysis of Lay Medicine" (1973), 261–63.

[55] See Mold, *Making the Patient Consumer*, 122; and Buckland, "Unmet Needs for Health Information," 86.

[56] Kempson, *Informing Health Consumers*, 33 and 35.

[57] Mold, *Making the Patient Consumer*, 122. Mold suggests that the *Which? Way to Health* publication had 65,000 subscribers by 1993. See 122.

women appeared more comfortable seeking health-related guidance and information, the degree to which men were beneficiaries is questionable.

Mental Health Organisations and Discourse on Gender

As patients made the gradual move towards greater autonomy and informed choice, parallel developments emerged in the third sector as organisations concerned with mental illness and mental handicap gained visibility. The National Association for Mental Health was established in 1946, by merging three separate organisations previously focused on mental health, mental handicap and child psychiatry: The National Council for Mental Hygiene (established in 1922); the Central Association for Mental Welfare (established in 1913); and the Child Guidance Council (established in 1927). The organisations merged during a period of great change: the development of the NHS and psychiatric services, alongside new drugs for the treatment of mental illness. The NAMH was founded on a set of objectives aimed at promoting greater understanding towards, and knowledge about, mental illness. It also emphasised the importance of treatment and training. Drawing on themes that were central to the Council for Mental Hygiene, the NAMH also sought to promote a greater understanding of the ways in which good mental health could be achieved and sustained, thereby, in many ways espousing a preventive approach. As Jonathan Toms notes, in 1970, the NAMH began a national campaign, which aimed to raise the profile of mental illness. It increasingly adopted the role of a pressure group, changing its name to MIND in 1973.[58] Although its remit was broadly to lobby in support of ‘patients’ who were already experiencing mental illness (and increasingly their families), their role in educating the general public about mental health and illness remained important. A review of the organisation’s archival material from the 1960s reveals much about discourses of prevention—particularly with regard to gender.

During the 1970s, MIND recognised the importance of educating young people about mental health and the organisation produced school teachers’ ‘kits’ with advice on how teaching staff should approach the subject. Packs consisted of useful colour-coded sheets allowing teachers

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[58] Jonathan Toms, “Mind the Gap: MIND, the Mental Hygiene Movement and the Trapdoor in Measurements of Intellect,” *Journal of Intellectual Disability Research* 54, no. 1 (2010): 16–27 and 16.

not only to impart information to students, but also to design interactive sessions with them. Notes for teachers on the healthy development of adolescents synthesised theories from contemporary psychology: transactional analysis, gestalt theory and humanistic psychology—all of which emphasised a holistic approach.[59] Throughout the material, the importance of a stable family environment is underlined. Information sheets for children were very detailed and attempted a balanced perspective, attaching broadly equal importance to psychological and physical approaches to treatment. However, the material reflected many gendered assumptions about mental illness, suggesting that women were a discreet category, explicitly more prone to mental illness.[60] Posters featuring images of children suggested that 'one child in eight will need mental hospital treatment at some time'—five girls and three boys appear on the poster. Case studies included fictitious accounts such as that of 'Mrs A', the 'careful housewife and loving mother, who became irritable, anxious and depressed', and 'Mrs B', who suffered from agoraphobia and 'has agreed to see a psychiatrist'. Schizophrenic cases were usually depicted as male—as were alcoholics.[61] An action sheet, designed to 'stimulate discussion about our own feelings and our bodies' suggested that students read a book by Katherina Dalton, entitled *The Menstrual Cycle* (1969). An excerpt was included:

> During the premenstrual period, women are more prone to have accidents, to make mistakes, to commit suicide and to be admitted to psychiatric units. Studies of schoolgirls have shown that marks are much lower during their premenstrual periods, exam results are lower and that discipline problems increase. Women teachers are more likely to give lower marks or to discipline during their own premenstrual periods.[62]

Another action sheet that encouraged students to think about the connections between mind and body, asked girls to keep a record of how they felt physically and mentally during 'several cycles'. Boys were simply

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[59] Wellcome Archives and Manuscripts (hereafter Wellcome), SA/MIN/B/109, Schools, "Teachers' Packs".

[60] Wellcome, SA/MIN/B/109, Schools, Teachers' Kit, "What is Mental Illness?"

[61] Wellcome, SA/MIN/B/109, Schools, Teachers' Kit, "Poster" and "Case Studies."

[62] Wellcome SA/MIN/B/109, Schools, Teachers' Kit, "Action Sheet 1."

asked to record how they felt at different times of the day.[63] It is difficult to know how widely these packs were circulated in schools. Prior to the introduction of the National Curriculum in 1988, head teachers and governors determined curriculum content and much variation existed between schools. However, any student participating in activities with these resources would be left in no doubt that concerns about mental well-being were likely to be of greater concern to girls and women than to boys and men.

During the 1970s and 1980s, NAMH and MIND published numerous books and pamphlets on women's mental health. The organisation stated explicitly: 'It is our view that insufficient time and attention are devoted to the consideration of women's mental health needs. Throughout society, the interests of men dominate, and this is reflected in the mental health field'.[64] Such claims must be seen within the context of feminist campaigns that justifiably moved to highlight women's concerns on two levels. Firstly, feminist commentators argued that the roots of much mental illness in women could be traced to anger, frustration and oppression—'symptoms' of existing in a patriarchal society. The corollary of this was that tranquillisers were widely assumed to have been overprescribed for disorders 'caused by the social system'.[65] Secondly, serious cases of professional misconduct and abuse against women emerged from within medicine and psychiatry itself, gaining widespread attention and criticism from advocacy groups. Indeed, MIND's material is replete with references to poorly managed mixed-sex psychiatric wards; inappropriate sexual contact between therapists and patients; domestic violence; the impact of declining mental health services; and racism in psychiatry against women from ethnic minorities.[66]

A MIND campaign, 'Stress on Women', later in 1992, lobbied for women-only spaces on psychiatric wards, new policies to tackle sexual

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[63] Wellcome, SA/MIN/B/109, Schools, Teachers' Kit, "Action Sheet 3."

[64] *Women in Mind* (London: Mind, 1985), 2; Wellcome, SA/MIN/B/131, "Women."

[65] Claims set out in *Women in Mind*, 7 and 8. See also Haggett, *Desperate Housewives.*

[66] For example, Mind Information Leaflet, "Women and Mental Health Services: Some Are More Equal Than Others," c. 1987; Mind Information Leaflet, "Women Sexually Abused by Their Therapists," c. late 1980s.

harassment and an independent advocacy to assist users in speaking out.[67] Given such alarming claims of subjugation and abuse, it is perhaps not difficult to appreciate the level of anger and emotion surrounding these debates. One regular contributor to MIND publications, Janet Gorman, roundly reflected the views of many in a pamphlet entitled, *Stress on Women, Out of the Shadows* (1992). In this scathing account of inequality, she noted that women were disadvantaged in a range of medical, legal and social arenas. Referring to the 'men's movement' in the United States, Gorman bemoaned:

> The American men's movement guru Robert Bly, contends that men have gone 'soft' and has been attempting to save yoghurt-eaters and turn them into wild men, through workshops and weekend retreats, where men can find their masculine selves, beat drums and rediscover the beast within.

However, Gorman cautioned that it was women who still feared crime and sexual violence.[68] Medically, socially and culturally then, the discourse surrounding poor mental health and the prevention of mental illness centred upon the unmet needs of women. These needs were embraced firmly by the feminist movement and other advocacy groups, such as MIND, that campaigned to challenge abuse and discrimination.

There was nonetheless one arena in which there were genuine opportunities for the needs of men to take centre stage. During the post-war period, the workplace increasingly became the focus of political and medical debate about occupational health. During the 1960s, driven by concerns about sickness absence and absenteeism, the topic attracted much attention, not only politically, but also among industrialists and psychologists. The broader history of workplace health and safety

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[67] Katherine Darton, Janet Gorman, and Liz Sayce, *Eve Fights Back: The Successes of MIND's Stress on Women Campaign* (London: MIND, 1994), 24; Wellcome, SA/MIN/B/131, "Women."

[68] Janet Gorman, *Stress on Women, Out of the Shadows*, MIND Campaigns for Women's Mental Health (London: MIND, 1992), 9 and 10. During the 1970s, concerns about the negative aspects of the male role led to a 'men's liberation' movement in the United States. A small collective of men in London also began producing a magazine called *Achilles Heel*, which aimed to challenge traditional forms of masculinity. However, the movement was less influential in the UK than in the United States. See Joseph Pleck and Jack Sawyer, eds., *Men and Masculinity* (Englewood Cliffs, NJ: Prenice Hall, 1974); Victor J. Seidler, *The Achilles Heel Reader: Men, Sexual Politics and Socialism* (London: Routledge 1991); and Haggett, *A History of Male Psychological Disorders*, 8.

has been well covered and is not the focus of this chapter.[69] However, during the 1970s and 1980s, the NAMH/MIND became actively involved in promoting the importance of the mental health of workers. Their attempts to influence policy demonstrate how challenging it was to engage political support for a preventive, holistic model of workers' health.

The NAMH submitted evidence to the Committee on Health and Safety at Work, which was appointed in 1970 and chaired by Labour politician and trade-unionist, Lord Alfred Robens. The Committee reported in 1972, and the recommendations were largely enacted in the Health and Safety Act, 1974. As I have shown elsewhere, the recommendations from the Robens Report fundamentally changed the principles of workplace health and safety, as emphasis shifted increasingly towards self-regulation and voluntary codes of practice. The new legislation clearly placed the responsibility for workplace welfare on employers and employees.[70] The NAMH appointed a working party of industrialists and medical officers to investigate mental health at work and submit a set of recommendations to Robens. In their report, they identified common psychological symptoms as a serious cause of absence from work, noting that if cases of psychosomatic illness were included in the data, 'certified absences due to mental ill-health, ha[d] increased more than any other form of illness'.[71] The data reflected earlier patterns in occupational health, suggesting that levels of psychoneurosis in women were rising; however, men featured more regularly in diagnoses for headache, dyspepsia and a range of other ill-defined illnesses. As the NAMH noted, such conditions were increasingly recognised as symptoms of 'stress'.[72] Among their recommendations, the working party stated that members of industrial health services should be fully trained in mental health and that an occupational health service should be established as a requirement within the National Health Service. They also advocated further

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[69] See Vicky Long, *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain 1914–60* (Basingstoke: Palgrave Macmillan, 2011); Arthur J. McIvor, *A History of Work in Britain, 1880–1950* (Basingstoke: Palgrave Macmillan, 2001); and Paul Weindling, ed., *The Social History of Occupational Health* (London: Croom Helm, 1985).

[70] Haggett, *A History of Male Psychological Disorders*, 59.

[71] Wellcome, SA/MIN/B/43, Employment, "Evidence for Submission to the Committee on Safety and Health at Work," ND c. 1971.

[72] For more detailed discussion of men, work and psychosomatic disorders during the 1940s, 1950s and 1960s, see Haggett, *A History of Male Psychological Disorders*.

research into the relationship between mental health/mental illness and employment.[73] The NAMH recommendations were formally articulated in a MIND Report, published in 1971, which stated that many managers in industry were 'ignorant of mental ill-health and its treatment'; that many doctors were 'ignorant of the working life of their patients'; and that the annual reports of the factory inspectorate gave 'no indication that any research at all [was] being undertaken by the department into the mental health aspects of employment'.[74] They also pointed out that symptoms of stress and poor mental health were not limited to executives and were found in workers of all levels of responsibility. The report advised that prevention of mental illness could be achieved by awareness of four key 'danger points' in the workplace: over-promotion, underwork, ill-defined job descriptions and poor consultation and communication by management.[75] The Robens Report, when it was formally published in 1972, fell far short of these recommendations—in particular, the proposal that an occupational health service should be established in parallel with the National Health Service. The NAMH expressed deep disappointment with the findings, stating that it had 'singularly overlooked the factors necessary for the promotion and maintenance of mental and social wellbeing, as opposed to physical health and safety'. Reaffirming the weaknesses of existing legislation, the NAMH protested that laws applied 'almost entirely to the physical aspects of manual work […] paying little or no regard to the mental health of employees'. It warned further that there was 'reason to fear that the operation of the [occupational health] service will reflect the Department of Employment's traditional concern with industrial diseases, hygiene and safety, at the expense of mental health'.[76]

A NAMH symposium on the topic of Management and the Working Environment, held later in 1972, exposed the political tensions at the core of debates about employment and health. Alan Fisher, General Secretary of the National Union of Public Employees, argued that the Government needed to be proactive on a range of levels with regard to both physical and psychological health—points, he noted, that had

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[73] Wellcome, SA/MIN/B/43, Employment, "Evidence for Submission to the Committee on Safety and Health at Work," ND c. 1971.

[74] Wellcome, SA/MIN/B/121, Stress, "MIND Report Stress at Work," 2.

[75] Wellcome, SA/MIN/B/121, Stress, "MIND Report Stress at Work," 2–3.

[76] Wellcome, SA/MIN/B/121, Stress (response to Roben's Report).

been articulated clearly to the Robens Report. However, Christopher Chataway, Conservative Minister for Industrial Development, disagreed, responding that the Government should occupy a 'supporting role', and that the primary responsibility for health lay with 'those who create the risks and those who work with them'. Indicating a degree of scepticism on the matter, Chataway cautioned that stress at work was a relatively unexplored field, 'in which it [was] very easy to make facile generalisations about the incidence of mental illness and its supposed cause'. Ultimately, without wishing to dispense with legislative control altogether, the Government's position was that streamlining and rationalisation of occupational health were possible—'self-help', in their view, was the key to further progress.[77] A medical model of intervention therefore prevailed in occupational health, underplaying the importance of the psychosocial environment and prevention of poor mental health at work. Interest in men's mental health more broadly, was overshadowed by a set of competing priorities: anxieties about the population's physical health and the rise of chronic disease; and publicity about women's psychological needs and their treatment by psychiatric profession.

Conclusion

At a one-day conference on 'The Health of Business Executives', convened by the Chest and Heart Association in 1959, Sir Richard Powell, Director General of the Institute of Directors, delivered a plenary paper. In his speech, he recounted to delegates a story about a research investigation into 'health problems' among the working population. One man had responded to the health questionnaire by 'scribbling' across the form: 'Never had a day's illness in my life and I never see a doctor'. All subsequent questions were left unanswered. A few weeks later, the research team received a letter from his executors, informing them of the man's death from thrombosis—requesting that his name be withdrawn from the study. This anecdote neatly reflected the way in which men were prone to indifference when it came to their own health, often rejecting the need for medical assessment or intervention. Although the conference claimed to promote a preventive approach to the health of executive men, emphasis remained on the physical risks of heart disease,

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[77] Wellcome, SA/MIN/B/43, Employment, "Symposium, Management and the Working Environment," 1972.

hypertension, overweight and lack of exercise. Even the paper on 'stress and responsibility' was couched in the language of hypertension and 'avoiding the coronary club'.[78] By the late 1980s, little had changed, although there was limited acceptance in some circles that the mind and emotions could impact on cardiac disease and other physical illness. One senior consultant cardiologist at Charing Cross Hospital in London, for example, diligently observed that most of his patients suffered 'not from an excess of fatty food, but from an internal disorder caused by struggling too hard with life for too long'.[79]

The model of masculinity that prevailed in the West undoubtedly emphasised stoicism and inscrutability, which impacted negatively on men's awareness of (and openness to) preventive measures in health and well-being. The notion that women were responsible for the health of their families further exacerbated the notion that it was not 'normal' for a man to take care of himself or to 'fuss' about his health. Although some psychologists and commentators in the United States and Britain raised concerns about the negative aspects of the male role, it is not clear that they influenced the lives of ordinary men in any significant way.[80] Moreover, the ways in which women faced a host of serious challenges, politically, socially and medically were increasingly made visible, bolstered by the feminist movement, which gradually extended its agenda beyond the boundaries of 'equality' to matters of medicine and psychiatry. Within this context, the notion that men might be vulnerable to anything other than coronary heart disease would invariably have been viewed as politically and socially insensitive.

The stigma attached to mental illness was also particularly challenging for men, who were reluctant to admit to vulnerability and 'not coping'. Investigations into discrimination in the workplace indicated widespread prejudice against workers who declared a history of mental illness. A MIND pamphlet on the topic, published in 1978, exposed numerous examples of job applications that were either rejected or rescinded and promotions that were blocked by employers. General practitioners were understandably reluctant to declare psychological disorders on sickness certificates.

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[78] The Chest and Heart Association, *The Health of Business Executives: Transactions of a One-Day Conference Held in the Royal Festival Hall, London, November 1959* (London: Chest and Heart Association, 1960), 10 and 19.

[79] Wellcome, SA/MIN/B/107, Mental Health Statistics 1975–93, pamphlet c. late 1980s.

[80] Haggett, *A History of Male Psychological Disorders*, 8.

Diagnoses suggestive of neuroses were often vague, or a more acceptable symptomatic diagnosis would be given on the certificate.[81] More broadly, as this chapter has shown, although the model of public health in Britain increasingly moved towards lifestyle-oriented, preventive measures, the focus was largely on targeted physical health: cancer, heart disease, smoking, overweight and diabetes.[82] In this milieu, poor mental health in men—arguably less visible and less well understood—was overlooked.

There is much to contemplate from this historical perspective. In twenty-first-century Britain, many cultural assumptions persist about gender and vulnerability to mental illness. While women are diagnosed with the most common mental disorders twice as often as men, the suicide rate in men is three times that in women. Recent concerted campaigns have done much to raise the profile of mental health and well-being more generally; however, as a number of scholars submit, there is now an 'empathy gap' and 'gender blindness' towards challenges faced by men. Violence and sexual misconduct—poor behaviour—exhibited by men is regarded as 'toxic masculinity' and questions are less likely to be asked about the social and emotional causes which invariably lead to 'damaged' men. Although there are a number of ways in which men are biologically and culturally vulnerable, it appears somehow inappropriate to highlight them. Serious attempts to challenge gender prejudice towards women have perhaps had the unintended consequence of 'reinforcing gender prejudice towards men'.[83] Within the context of recent sexual abuses exposed by the Harvey Weinstein scandal and the #MeToo movement, the notion that women are 'at risk' everywhere has become a powerful concept.[84] While serious abuse must, of course, be taken seriously, the 'Weinstein moment' threatens to be divisive, propelling men and women (and scholarly interest) further in different directions. Within this climate, it seems likely that the mental health of men will remain poorly understood.

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[81] David Ferguson, "A Study of Neurosis and Occupation," *British Journal of Industrial Medicine* 29 (1972): 420–31 (430).

[82] Berridge, *Marketing Health*, 2.

[83] Martin Seager, Warren Farrell, and John Barry, "The Male Gender Empathy Gap: Time for Psychology to Take Action," *New Male Studies: An International Journal* 5, no. 2 (2016): 6–16 (8).

[84] The 'Weinstein effect' or 'moment' refers to serious allegations of sexual misconduct, made in 2017, against the American film producer Harvey Weinstein. The allegations triggered a wave of similar accusations against men of other sectors. Subsequent campaigns have been described as a 'watershed moment' against sexual harassment of women.

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