'Graduate patients' and the vanishing human history of psychiatry

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During the 20th century psychiatry has become established as the clinical discipline that we recognise today. This has been a time of great change in attitudes to, knowledge of, and methods of care for mental disorder. In the early years of the century, the numbers of patients in mental institutions rose steadily and there was increasing acceptance of mental disorder as an illness and there was an incipient optimism about the prospect of successful treatment. At the same time the prejudices associated with mental treatment were slowly being eroded, culminating in the Mental Treatment Act of 1930 which provided for 'voluntary' in-patient status. A further surge of therapeutic enthusiasm followed the introduction of new physical treatments in the 1940s of which the best known are insulin coma therapy, convulsive therapies and psychosurgery. These developments were parallelled by a continuing rise in the numbers of patients in mental hospitals, some having in excess of 3000 beds, and the beginnings of a movement towards the unlocking of wards.

With the coming of the National Health Service in 1948, mental hospitals became integrated into the same administrative framework as general hospitals. By the early 1950s, with increasing overcrowding in many hospitals, the emphasis turned to discharging patients rather than simply encouraging individuals to come forward for treatment. The advent of the phenothiazines and related drugs facilitated this trend, while at the same time there was increasing liberalisation of the hospital regimes. Physical treatments, whether effective or ineffective (as insulin coma therapy) played a part both in raising morale by their promise, and raising standards through need for greater technical expertise, thereby bringing psychiatry closer to general medicine.

The late 1960s and 1970s saw the disintegration of the hospital community and culture as society's regard for mental hospitals became increasingly negative, coloured by the reaction against institutionalisation in general. Throughout the 1980s the closure of mental hospitals proceeded more rapidly and many elderly patients who had spent much of their adult lives in hospital were relocated to residential or nursing homes or to hostels leaving a small residue of long-stay patients, some of whom 'graduated' to the psychogeriatric services.

Recent works of the history of British psychiatry have reflected upon the innovators who have shaped modern psychiatric practice, together with their ideas and the institutions in which they worked. We felt that this was an opportune time to reflect upon the lives of a few of the dwindling number of individuals who have experienced much of this important chapter in medical history as the recipients of psychiatric care.

The cases presented here are not necessarily representative of psychiatric patients in general or of long-stay patients in particularly, but rather make a human connection with some important landmarks in the development of clinical and administrative psychiatry in Britain in the 20th century. They are current or recent patients in a psychogeriatric long-stay ward, who have lived much of their lives in hospital.

Cases

Patient A

A was admitted to a mental hospital on a magistrate's order in 1915. He was 24 years old, single and described as a labourer. At the time of admission it was stated that he was "feeble-minded" and "childish in behaviour". The diagnosis was of "primary dementia". At his first review it was commented that, "(he) is an imbecile and a proper person to be detained under care and treatment".

Over the years that followed he remained in hospital, the meagre medical notes repeatedly describing him as "dull and listless" and "solitary". The diagnosis varied a little from "katatonic (sic) dement" to "secondary dementia" with schizophrenia first being mentioned in the

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1950s. The notes indicated little change in his behaviour or general condition until this period and suggest that expectations of change were exceedingly limited.

Beyond experiencing the milieu of the hospital, there is little indication that A received any specific therapeutic intervention during the first 40 years of his admission. In the late '50s it was noted that he attended the occupational therapy department, but details of this activity are scanty. At no time during his admission is there any record that psychotropic drugs or any other physical treatments were prescribed.

In 1973 he was moved to another hospital, being then described as "a prematurely senile man . . .' It was commented at this time that his conduct and behaviour presented no problems to the staff and in 1978 he was placed on the waiting list for local authority residential accommodation. The following year, however, plans for rehabilitation in this direction were abandoned on the grounds of incontinence. Over the next 14 years his physical health progressively declined although it was noted that he was "happy and contented" and was "singing all day long". In 1987 at a case review it was concluded that he was suffering from chronic schizophrenia but not any significant degree of dementia. He died in hospital in 1992 at the age of 103. He had been continuously in hospital for 87 years.

Patient B

B is a single woman who has been in long-term mental institutions for 50 years. Born to a middle-class iron founder's family and the second of three sisters, she was previously described as a "backward" girl with an "inferiority complex" in contrast to her "articulate" siblings. There was some history of minor mental disorder throughout the family.

After poor scholastic attainment, she worked as an auxiliary nurse at a local children's hospital until her illness. Her initial symptoms appeared at the age of 20 followed by compulsory admission by magistrate's order. She was said to fabricate stories of a grandiose nature, including "erotomania", she threatened suicide, and was described as impulsive and hallucinated. After 24 ECTs she appeared well enough to be discharged, only to be readmitted to hospital permanently the following year.

Her further psychiatric treatment continued in 1943 with 40 insulin coma treatments. With only superficial improvement she underwent a bilateral pre-frontal leucotomy eight months later. By 1945 it is clear from the notes that she remained intermittently catatonic unless given ECT and over the next 11 years received a total of 286 treatments. In 1953 she underwent carbon dioxide narcosis which was noted to be "30 breaths of 30% CO_2 followed by . . . abreaction and a dream", after which she was "quieter and pleasant". She continued with weekly ECT and had a period of stability.

With the introduction of neuroleptics, she was given chlorpromazine in 1955 and was noted to need less ECT and to have less subjective problems with her memory. Side effects resulted in substitution with reserpine with little clinical benefit. Throughout the next 20 years her behaviour was said to vary from "prancing about like a wild pony" to "borderline catatonia with superimposed stereotypy". Recently the development of seizures in 1988 and a carcinoma of breast in 1990, when added to notable cognitive decline, have meant an increased dependency on staff.

Patient C

C was born in 1921. Following work in his father's branch of a bank, he left to join the RAF at the outbreak of war. Little other family background is known, other than that his sister suffered from long-term serious mental disorder.

In 1943 his first breakdown occurred, leading to discharge from the Air Force. No exact details are available, but a diagnosis of schizophrenia was entertained. He went to live near his family and was admitted to the local hospital where he was noted to be "deluded, posturing, sobbing, and irritable", with the belief that he was a king. His symptoms resolved with ECT and he left hospital.

Some months later he was readmitted suspicious, hallucinating and thought disordered. There was no change with 47 ECTs and indeed his psychopathology has remained largely stable for over 40 years, despite various therapeutic interventions.

In 1948 he received 70 insulin coma treatments of 40 minutes each, and in 1951 a prefrontal leucotomy, both with little improvement. He also had intermittent ECT until the advent of drug therapy, and the latter has continued in various forms.

He was transferred to another hospital in 1973 where he was described as "a middle-aged man with residual signs of a left hemiplegia". He continued to exhibit grandiose systematised delusions, hallucinations, overactivity and euphoria unaltered by the prescription of lithium. To this day he believes himself to be a king with 388 wives, and to be a practising doctor who owns the White House, asking to be known as King John. He lives peacefully and apparently contentedly on the ward.

Patient D

D was first admitted as a certified patient in 1954 at the age of 25, when he felt that a woman

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Table 1. Landmarks in the history of physical treatments in psychiatry and their impact on these cases

Treatment	A	C	B	D
Insulin coma therapy - 1940s	No	Yes	Yes	Yes
Convulsive therapies - 1940s and on	No	Yes	Yes	Yes
Psychosurgery - 1940s and on	No	Yes	Yes	No
Phenothiazine and related drugs - 1950s and on	No	Yes	Yes	Yes
Carbon dioxide narcosis - 1940s and 1950s	No	No	Yes	No
Lithium - 1960s	No	Yes	No	No

employee was talking about him. The son of a well-off commercial traveller of "somewhat hypomanic personality", he had worked unremarkably as a lithoprinter until this point. Once in hospital he quickly deteriorated with alternating mutism and excitement, for which he was prescribed deep insulin coma treatment. This was followed by improvement which allowed him to work in the hospital print shop.

He was discharged from hospital at his father's request in 1955, but relapsed a month later. A second course of deep insulin coma treatment seemed to produce a marked improvement, but he became catatonic again despite ECT. Chlorpromazine was given and within 12 months he was discharged.

His relapse in 1957 was attributed to his father's absence from home and poor treatment compliance. Informal admission followed, the superintendent of the hospital commenting that the likely diagnosis was catatonic schizophrenia with poor prognostic features. He was enrolled into "social therapy" and given industrial rehabilitation, and retired from work on health grounds. The next 25 years were spent within the same hospital. He had several drug regimens, including reserpine and oral and depot neuroleptics, with little influence on his residual symptoms. He developed generalised seizures of uncertain origin in the 1970s.

By 1981, aged 53, at a case review he was described as having the "defect state of chronic schizophrenia" and despite his relative youth remained on what was now a psychogeriatric ward, since it did not prove feasible to relocate him. With the move of that ward to another hospital came an improvement in his sociability and self-care, and a recession of positive psychotic features, and it was felt that a more appropriately stimulating environment should again be sought. Recently, a decision was made to involve him in a rehabilitation programme for younger patients, and currently there is hope that alternative accommodation in the community may yet be found.

Conclusion

Patients such as these represent a living history of modern psychiatry. It is interesting that while their case-notes contained detailed and systematic references to various physical treatments (see Table I), much less emphasis was given there to other emerging therapeutic modalities such as occupational therapy, industrial therapy and psychological interventions which were presumably occurring in parallel. It is also of interest that despite a generally positive therapeutic stance during this period, some patients (such as A) received remarkably little in the way of specific treatment.

We have been privileged to learn from and teach about these survivors of the earlier years of our specialty. As most of this generation of patients enter their eighth or ninth decades we should be aware that this opportunity is fast disappearing. They will have their successors, but their life histories will be different.

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