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‘Often there is a Good Deal to be Done, But Socially Rather Than Medically’: The Psychiatric Social Worker as Social Therapist, 1945–70

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Abstract: Seeking to align psychiatric practice with general medicine following the inauguration of the National Health Service, psychiatric hospitals in post-war Britain deployed new treatments designed to induce somatic change, such as ECT, leucotomy and sedatives. Advocates of these treatments, often grouped together under the term ‘physical therapies’, expressed relief that the social problems encountered by patients could now be interpreted as symptomatic of underlying biological malfunction rather than as a cause of disorder that required treatment. Drawing on the *British Journal of Psychiatric Social Work*, this article analyses the critique articulated by psychiatric social workers based within hospitals who sought to facilitate the social reintegration of patients following treatment. It explores the development of ‘psychiatric social treatment’, an approach devised by psychiatric social workers to meet the needs of people with enduring mental health problems in hospital and community settings that sought to alleviate distress and improve social functioning by changing an individual’s social environment and interpersonal relationships. ‘Physical’ and ‘social’ models of psychiatric treatment, this article argues, contested not only the aetiology of mental illness but also the nature of care, treatment and cure.

Keywords: Care; Cure; Recovery; Chronic Mental Illness; Physical Treatment; Psychiatric Social Work; Social Psychiatry

Introduction

Historian Edward Shorter viewed the introduction of the tranquiliser Largactil in 1953 as a pivotal moment in psychiatric practice, initiating ‘a revolution in psychiatry’ that transformed psychiatry ‘from a branch of social work to a field that called for the most precise knowledge of pharmacology’.¹ In his 1967 autobiography, psychiatrist William Sargent

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¹Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), 255.

expressed similar sentiments, recalling how the introduction of Largactil helped realise his dream of transforming psychiatric practice into a branch of general medicine. This 'wonder drug', as he dubbed it, enabled him to treat patients diagnosed with schizophrenia within a general hospital. It became possible, he explained, to 'administer enough Largactil to keep even the acutest schizophrenic tranquilised while electric shock treatment and other methods speeded their recovery.'² Like Shorter, Sargant reinforced his point that psychiatry had progressed by drawing a comparison with earlier social work approaches to mental illness, inferring that psychiatric social work was obsolete. At the Maudsley Hospital in the 1930s, he explained, 'tactful women interrogators called psychiatric social workers' had compiled case histories detailing the family and home circumstances of each patient admitted. These case histories 'would now be laughed at' and were 'often a waste of time, but what else could one do? Nowadays we may only need to prescribe four or five electric shock treatments, or a new course of some antidepressant drug.'³

Largactil belonged to a group of psychiatric therapies grouped together under the label of physical treatments. These treatment methods, which included insulin treatment, convulsion, malarial therapy, prefrontal leucotomy, sedatives and stimulants, were designed to alleviate psychological symptoms by inducing physiological change or by altering the structure of the brain.⁴ If we turn to accounts produced by practitioners of the relatively new profession of psychiatric social work disparaged in Sargant's autobiography, we gain a different perspective on the impact of physical treatments on patients. Based within a psychiatric hospital, one such psychiatric social worker (hereafter PSW) Madelene Crump, found her work expanding when the new sedatives and tranquillisers of the 1950s, such as Largactil, produced an increased number of cases deemed by psychiatrists to have recovered sufficiently to be discharged. However, she expressed reservations about the effect of the drugs on patients she described as formerly:

Bizarre and sometimes spiteful and vindictive... they seemed to have shown considerable vitality and individuality. One wonders where the vitality has gone now, what is turning over in their minds as they sit there calm and a little rigid in their chairs, giving the polite answer like children anxious to please, when approached by a member of staff.⁵

This article explores the rise and dominance of physical treatments from the perspective of PSWs. Commencing with an account of the development of psychiatric social

²William Sargant, *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* (London: Heinemann, 1967), 148–9; chlorpromazine was marketed as Largactil.

³Sargant, *ibid.*, 36. This was the only reference to PSWs in the book.

⁴Such treatments were also described as 'somatic', 'biological' or 'medical', and were contrasted to a body of therapies termed as 'social', 'psychological' or 'psychotherapeutic'. The 'physical' treatments were grounded in the belief that

mental illnesses were a product of biological malfunction and were best treated by remedying this biological malfunction; the 'social' treatments were based on the belief that mental illnesses were caused, or at least influenced, by environmental, psychological and interpersonal factors and could be treated by manipulating these factors.

⁵M. Crump, 'Social Aspects of Physical Treatment in Mental Illness', *British Journal of Psychiatric Social Work* [hereafter *BJPSW*], 5, 1 (1959). 19–25: 21.

work, the article will contend that PSWs, by virtue of their training and function, were uniquely placed to trace the repercussions of physical therapies through their work with discharged patients in the community. It explores how PSWs shared their concerns with colleagues via the *British Journal of Psychiatric Social Work* (hereafter *BJPSW*), which was established in 1947 by the Association of Psychiatric Social Workers' (hereafter APSW) Publications Sub-Committee with the intention of providing 'a vehicle for the exchange of ideas regarding the methods of psychiatric social work'.⁶ The *BJPSW* offered PSWs a space in which to forge a critical analysis of physical treatment methods. It provides historians with an insight into the professionalising aspirations of a nascent occupation; fragmentary perspectives from disparate locations, provided by authors for whom it is often impossible to ascertain even a first name. The article will then explore how some PSWs strove to assert their professional status and transcend their auxiliary function by arguing that the care and support they provided to patients and their families could fulfil needs unmet by physical treatments, drew upon a distinctive type of expertise, and could most accurately be conceptualised as 'psychiatric social treatment'. This detailed analysis of specific cases prefaces a consideration of how the objectives of 'social' and 'physical' approaches converged, overlapped, and diverged in post-war mental healthcare. The article concludes by stressing the fluidity of the concepts of care, treatment, recovery and cure, tracing how the terms were mobilised in support of professional ideologies and aspirations.

The Development of Psychiatric Social Work in Britain

The roots of psychiatric social work can be traced back to the work of earlier charitable organisations that worked with those who experienced mental distress and their families within community settings.⁷ The growing acceptance of psychological explanations for people's behaviour and capabilities and the emergence of the mental hygiene movement also proved influential.⁸ Social worker Mary Jarrett first developed professional training

⁶APSW Archive, MSS.378/APSW/2/1/9, 'APSW Annual Report 1946–47', typescript, 7. All APSW archives consulted for this article are held at the Modern Records Centre, University of Warwick.

⁷For example, the Mental After Care Association deployed lady volunteers to visit its charity cases in their homes or places of work to check on their progress and resolve any difficulties. See Vicky Long, 'The Mental After Care Association: Public Representations of Mental Illness 1879–1925' (unpublished MA thesis: University of Warwick, 2000), and Vicky Long, 'Changing Public Representations of Mental Illness in Britain 1870–1970' (unpublished PhD thesis: University of Warwick, 2004), 178–232. The Central Association for Mental Welfare (founded in 1913 as the Central Association for the Care of Mental Deficiency) was also engaged in work with the mentally disordered within the community. Its work is discussed in Louise

Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care 1890–1939' (unpublished DPhil thesis: Sussex University, 1999).

⁸See Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), and Nikola Rose, *Governing the Soul: The Shaping of the Private Self*, 2nd edn (London: Free Association Books, 1999). Jonathan Toms' PhD thesis explores how changing conceptualisations of subjective experience reshaped the mental hygiene movement: see Jonathan Toms, 'Mental Hygiene to Civil Rights: MIND and the Problematic of Personhood, c.1900–c.1980' (unpublished PhD thesis: University of London, 2005). The first objective listed in the APSW constitution was 'to contribute towards the general purposes of mental hygiene', and the APSW was represented on the National Association of Mental Health, the main organisation involved in the

for social workers in psychiatric fields in 1914 at the Boston Psychopathic Hospital, and PSWs became part of the team in the newly established child guidance clinics that aimed to prevent juvenile delinquency.⁹ These American developments dovetailed with the growing interest expressed in the ‘problem’ child in Britain.¹⁰ When the Commonwealth Fund agreed to finance the establishment of child guidance clinics in Britain, it stressed the need to train social workers in a university setting. Thus in 1929, the London School of Economics established the first course to train social science graduates with some experience of social work as PSWs. In the same year, the Association of Psychiatric Social Work (hereafter APSW) was inaugurated with the dual objectives of promoting mental hygiene, and raising the professional status of psychiatric social work.¹¹ Edinburgh, Manchester and Liverpool universities established courses to train PSWs in 1944, 1946 and 1954 respectively.

By 1944, 257 people in Britain had qualified as PSWs although not all of these people were using their qualification to work as a PSW. Those who chose to do so worked either in child guidance clinics, where they undertook casework with mothers, or within psychiatric hospitals, where they compiled a social history of cases admitted and helped patients readjust following discharge from hospital.¹² A report undertaken in 1951 found that only eight of the 331 PSWs working in Britain were employed within the mental health departments of local authorities, where they provided support to people living in the community who experienced mental health problems, while 239 were employed in psychiatric social work in mental hospitals, general hospitals or child guidance clinics.¹³ Eight years later, the Younghusband Report suggested that 325 PSWs would provide adequate coverage to local authority health services but noted that this field only employed 26 full-time PSWs.¹⁴ It was only by 1969 that the balance was redressed, with 257 PSWs engaged in community care, 264 in mental hospitals, and 259 working in child guidance clinics.¹⁵

promotion of mental hygiene in Britain in this era. APSW Archive, MSS.378/APSW/2/1/1, ‘The APSW Annual Report for the Year 1936 (with foreword on the years 1930–5)’, 5.

⁹For more information on the development of psychiatric social work training in America, see Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America* (Princeton, NJ: Princeton University Press, 1994), 35–45.

¹⁰Exemplified in the work of educational psychologist Cyril Burt, employed in 1913 to investigate cases of difficult children in London schools and to carry out treatment. See Deborah Thom, ‘Wishes, Anxieties, Play and Gestures: Child Guidance in Inter-War England’, in Roger Cooter (ed.), *In the Name of the Child: Health and Welfare, 1880–1940* (London: Routledge, 1992), 200–19.

¹¹The APSW Annual Report for the Year 1936’, *op. cit.* (note 8), 5.

¹²Thus in 1937, for example, forty-three PSWs worked in hospitals and twenty-four were employed in child guidance. Noel Timms, *Psychiatric Social Work in Great Britain, 1939–1962* (London: Routledge, 1964), 69.

¹³Ministry of Health, *Report of the Committee on Social Workers in the Mental Health Services* (1951), Cmd 8260, 15.

¹⁴Ministry of Health and Department of Health for Scotland, *Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services* (London: H.M.S.O. 1959), 227–8.

¹⁵For more detail on the origins of psychiatric social work in Britain and the establishment of the mental health course, see Timms, *op. cit.* (note 12). The figures for 1969 are drawn from APSW Archive, MSS.378/APSW/2/1/35, ‘The APSW Annual Report 1969’, 17. For work on child guidance clinics and the role of the PSW see John Stewart, ‘An “Enigma to Their Parents”: The Founding and Aims of the Notre Dame Child Guidance Clinic, Glasgow’, *The Innes Review*, 57 (2006), 57–76; John Stewart, ‘Child Guidance in Inter-War Scotland: International Context and Domestic Concerns’, *Bulletin of the History of Medicine*, 80 (2006), 513–39; John Stewart, ‘“I Thought You Would Want to Come and See His Home”: Child Guidance and Psychiatric Social Work in Inter-War Britain’ in Mark Jackson (ed.), *Health and the Modern Home* (London: Routledge, 2007), 111–27.

With a membership dispersed geographically and occupationally, the APSW endeavoured to facilitate discussion amongst practitioners. General meetings, which over time revolved increasingly around specific issues facing PSWs, provided one place in which members could exchange views. The development of local branches expanded this forum outside its original London setting, enabling members throughout the country to debate professional issues. From 1950, the APSW distributed copies of the *BJPSW* to all subscribing members, facilitating the aspiration expressed by Editor Margaret Ashdown that meetings of the Association would discuss the content of the *Journal*, 'stimulating the interest and initiative of the members'.¹⁶ Ashdown also felt the *BJPSW* might help publicise the achievements of the APSW to related professions, serving as 'a whispering gallery, by means of which our voices, which some of us feel to be so feeble, can be made to carry to our professional neighbours, without fear or strain.'¹⁷ Given the circulation of the initial edition of the *BJPSW*, these hopes appear misplaced: the initial print run of 1,000 copies in 1947 and 1948 had to be reduced to 600 copies by 1949 when it became clear that the APSW had over 200 copies left of each of the previous journals.¹⁸ Membership of the APSW stood at only 398 by the end of 1948.

A Social Perspective on Physical Treatments

Proponents of physical therapies, such as William Sargant, claimed that mental illnesses had a somatic aetiology and wanted to bridge the gap between psychiatry and general medicine. In *An Introduction to Physical Methods of Treatment*, co-authored with fellow psychiatrist Eliot Slater nearly a decade before the introduction of Largactil, Sargant claimed that new treatment methods had transformed mental hospitals beyond recognition within a decade.¹⁹ Physical treatments, asserted Sargant and Slater, 'produce their beneficial effects with greater speed and greater certainty than the older and more well-established psychotherapeutic methods.'²⁰ Psychiatrists could now interpret the emotional distress and social problems experienced by patients as a product of underlying biological malfunction rather than a cause of their disorder. Correspondingly,

¹⁶M. Ashdown, 'Introduction', *BJPSW*, 1, 1 (1947), 3–7: 6. I consulted the 1968 reprints of the *British Journal of Psychiatric Social Work* issued by Swets and Zeitlinger N.V. Amsterdam; page and volume numbers are listed accordingly.

¹⁷M. Ashdown, 'Editorial', *BJPSW*, 1, 3 (1949), 3–6: 3.

¹⁸When Swets and Zeitlinger took over publication of the *Journal* from 1968, they reissued volumes 1 to 8, covering the years 1947 to 1966, suggesting a demand for the earlier editions by this stage.

¹⁹The emergence of these treatments are outlined in Shorter, *op. cit.* (note 1) 190–224, and more critically, in Phil Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1845* (London: Routledge, 1996), 129–50. Introduction rates for different treatments across hospitals varied: Shorter notes that

insulin coma therapy was introduced in British hospitals by 1937 and had become widespread by 1939 (211). Convulsive therapy was first introduced in Britain in 1937 using cardiazol. Electro-convulsive therapy was introduced in 1939 and slowly supplanted the use of cardiazol: see Niall McCrae, "'A Violent Thunderstorm': Cardiazol Treatment in British Mental Hospitals', *History of Psychiatry*, 17 (2006), 67–90. Diana Gittins, however, found no evidence of the use of ECT or insulin coma therapy at Severalls Hospital until after the Second World War: Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913–1997* (London: Routledge, 1998), 196–7.

²⁰William Sargant and Eliot Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, 2nd edn (Edinburgh: E. & S. Livingstone, 1948), 1. This textbook had run to five editions by 1972.

therapeutic practices designed to unpick the social roots of mental illness by delving into a patient's history or to alleviate the social consequences of mental distress could at best play a supporting role.

In the late 1940s and 1950s, two factors converged to create an atmosphere amenable to the dissemination of physical therapies within psychiatric practice. Although the Board of Control continued to regulate the mental health services until the passing of the 1959 Mental Health Act, the nominal incorporation of psychiatric hospitals within the new National Health Service in 1948 presented an opportunity for psychiatrists to realign their professional activities with general medicine.²¹ This was also an era of rising patient numbers. Overcrowding in mental hospitals was estimated nationally at fourteen per cent in 1950; at St Andrew's Hospital in Norfolk, overcrowding had reached twenty-five and fifty per cent on men's and women's wards respectively between 1951 and 1957.²² As the resident population in mental hospitals peaked at 151,400 in 1954,²³ many psychiatrists may well have been inclined to agree with Sargant and Slater regarding 'the incapacity of highly individual and time-consuming methods to deal with a large-scale problem', viewing physical treatments as more efficacious in terms of 'speed, convenience and certainty'.²⁴ Other major psychiatric textbooks, such as *Clinical Psychiatry*, co-authored by William-Mayer-Gross, Eliot Slater and Martin Roth in 1954, also emphasised the organic aetiology of mental illness and the value of physical therapies, largely dismissing the influence of social and psychological factors in mental distress.²⁵ PSW Cyril Greenland, who worked for Mayer-Gross between 1948 and 1955, recalled his superior's conviction that 'since the causes of mental illness would sooner or later be revealed by the biological sciences, sociology and social work had a very limited role to play in psychiatry'.²⁶

²¹Mental hospitals were nominally included within the Regional Hospital Boards and came under the formal control of the Ministry of Health, but in practice, psychiatric services appear to have been poorly integrated. See John V. Pickstone, 'Psychiatry in General Hospitals: History, Contingency and Local Innovation in the Early Years of the National Health Service', in John V. Pickstone (ed.), *Medical Innovations in Historical Perspective* (Houndmills: Macmillan, 1992), 185–99, and Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum / St Andrew's Hospital c.1810–1998* (Woodbridge: Boydell, 2003), 231–40. For more details of the 1959 Mental Health Act, see Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services From the Early 18th Century to the 1990s* (London: Athlone, 1993), 154–8.

²²National figures from C. Webster, 'Psychiatry and the Early NHS: The Role of the Mental Health Standing Advisory Committee' in German E. Berrios and Hugh Freeman (eds), *150 years of British Psychiatry, 1841–1991* (London: Gaskell, 1991), 103–16, cited in Cherry, *op. cit.* (note 21), 243. Figures for St Andrews from Cherry, *idem*, 245.

²³Jones, *op. cit.* (note 21), 161.

²⁴Sargant and Slater, *op. cit.* (note 20), 188, 189. These developments within the field of psychiatry reflected more general trends with medicine, as individualised care was discarded in favour of a standardised approach that offered a more efficient means to deliver mass healthcare through categorisation and classification. See Steve Sturdy and Roger Cooter, 'Science, Scientific Management, and the Transformation of Medicine in Britain c.1870–1950', *History of Science*, 36 (1998), 1–47.

²⁵See Shulamit Ramon's analysis of the 1956 edition of Henderson and Gillespie's *A Textbook of Psychiatry* (Oxford: Oxford University Press, 1956), and the first (1954) edition of W. Mayer-Gross, Eliot Slater and Martin Roth's *Clinical Psychiatry* (London: Cassell, 1954); Shulamit Ramon, *Psychiatry in Britain: Meaning and Policy* (London: Croom Helm, 1985), 163–78.

²⁶Cyril Greenland, 'At the Crichton Royal with William Mayer-Gross (b. 15 Jan. 1889, d. 15 Feb. 1961)', *History of Psychiatry*, 13 (2002) 467–74: 470.

'Often there is a Good Deal to be Done'

Positioned at the boundary between the hospital and the community, PSWs were less sanguine in their assessments of the efficacy of physical treatments. In articles contributed to the *BJPSW*, some stressed that what psychiatrists might define as a medical recovery did not necessarily constitute a social recovery, and suggested that physical therapies could damage patients' personalities and consequently destroy families. Analysing the social consequences of physical treatments, Madelene Crump described cases where drug treatment had brought patients out of 'chronic' states, only to confront bleak social realities. Mrs O, who was brought into hospital in 1944, began to improve in 1956 after a year's treatment on Largactil. She discovered that her husband was living with another woman by whom he had had several children, and that her own children, who lived with him, had been told that she was dead. Mrs L was brought into hospital in 1943 and was placed on Largactil in 1955. As her memory started to return, searches were made for her husband and children without any success, and her brother was discovered to have died two months previously. In this case, Crump believed that part of her task was 'to help Mrs L accept that for the present time at least, she has no family.' Mrs P, a widow admitted to hospital in 1948, started to improve while taking Largactil from 1957. She was discharged and managed to gain work. However, the children's department refused to allow Mrs P any contact with her children for fear of disturbing their home environment. Crump believed that despite Mrs P's longing to have her children back she was 'never likely to be stable enough to establish and maintain a normal home for them'.²⁷

In her analysis of how different psychiatric professions understood mental illness, Shulamit Ramon used Crump's article to evidence her assertion that amongst PSWs there was no 'serious debate on the psychiatric means of intervention', which she attributed to 'the unquestioning acceptance of psychiatric authority by the PSW'.²⁸ Crump, Ramon claimed, 'expressed her enthusiasm at the impact of the new drugs.' Read closely, the article provides a more unsettling perspective than Ramon suggested, offering an insight into the palpable distress experienced by erstwhile long-stay patients and demonstrating the inability of the newly developed physical treatments, in isolation, to remedy interpersonal problems. Other contributions to the *BJPSW* went further, suggesting that the damage caused by physical therapies could outweigh the therapeutic benefits. Following women patients who had received leucotomy operations after they left hospital, PSW Mary Lane found that many cases psychiatrists would describe as a clinical success had led to a collapse of the family because of changes in personality or behaviour caused by the operation.²⁹ The husband in Case D, for example, had become much more hostile after the operation, telling his wife that she was 'like an animal'. Before the leucotomy operation in Case E, the husband had been devoted to his wife. After the operation, when the patient became 'gross in appearance, slack in personal habits and cleanliness but casually cheerful', the husband's hostility was kindled. He left his wife for another woman, telling Lane 'I cannot stand the smiling stranger in my house'.³⁰ In Case G, the husband had insisted on the leucotomy operation for his wife. Her obsessional phobic symptoms disappeared but she became lethargic and exhibited an 'inappropriate

²⁷Crump, *op. cit.* (note 5), 23, 24.

²⁸Ramon, *op. cit.* (note 25), 213.

²⁹M.A. Lane, 'The Effect of Leucotomy on Family Life', *BJPSW*, 3, 3 (1956), 18–24.

³⁰*Ibid.*, 19.

emotional response to situations'. This infuriated her husband who turned her out of the house and refused to let her see their son.³¹

Through these accumulated cases of marital breakdown, Lane was able to demonstrate an overlooked consequence of the leucotomy operations. 'Most of the husbands', she suggested, 'seemed better able to deal with the consequences to themselves of prolonged or recurrent illness in the spouse than with the indifference and disturbance which her post operative behaviour showed.' Other examples illustrated the destabilising impact of a leucotomy upon family relationship more broadly: Lane cited these cases to support her suggestion that psychiatrists should inform families about the likely effects of the operation on the behaviour of the patient. In one such case, Lane described a widow who had lived happily with her sister. After the leucotomy, the sister became frustrated by the widow's complacency and casual attitude and complained that she was 'a different sister'. The sister allied herself with a third sister and violent rows ensued. 'The earlier happy family relationship has become one of friction', concluded Lane. The therapeutic benefits of the treatment were brought further into question in the case of a widow who had been sent to live with her married daughter after her operation. The daughter found the changes in her mother so distressing that the widow had to be transferred back to the hospital. 'That's not my mother', the daughter told Lane. 'You can't converse with her anymore.'³²

Edward Shorter has depicted psychosurgery as an anomalous deviation from the progressive path of physical therapies.³³ Conversely, in his detailed study of psychosurgery, Jack Pressman demonstrated that leucotomies were by no means an aberration from the logic underpinning physical treatments. Psychiatrists, he argued, viewed psychosurgery as therapeutically beneficial because it transformed demanding and troublesome patients into placid, manageable patients who would conform more readily to the regime of the hospital: such considerations would have been particularly compelling in an era of hospital overcrowding. Pressman concluded that tranquilisers such as Largactil, which slowly displaced psychosurgery, were widely adopted precisely because they produced very similar effects.³⁴

Pressman's observations are supported by anecdotal evidence gathered by Diana Gittins. Michael Wilson, who had worked at Severalls Hospital as a nurse, commented that patients after leucotomies were 'more tranquil', but 'once you'd been Attila the Hun, with the leucotomies, you couldn't put it right again.' He recalled that leucotomies had fallen out of favour following the introduction of Largactil, 'what we call the chemical leucotomies'.³⁵ Unlike psychiatrists, PSWs were primarily concerned not with how patients behaved in the hospital but how they functioned socially outside of the hospital. By examining the impact on relationships between family members, PSWS such as Lane and Crump were able to question, not just the treatment method, but also the criteria by which psychiatrists measured recovery, suggesting that physical treatments could have a detrimental impact on the lives of patients and their families.

³¹*Ibid.*, 20.

³²*Ibid.*, 21.

³³Shorter, *op. cit.* (note 1), 225–9.

³⁴See Jack Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998).

³⁵Quoted in Gittins, *op. cit.* (note 19), 208.

'Often there is a Good Deal to be Done'

Transforming the 'Benevolent Dustbin': Psychiatric Social Treatment and Community Care

PSWs working in mental hospitals attempted to alleviate the social problems arising in the lives of patients who had undergone physical treatments. Those who worked for local authorities found that many of their cases had been discharged into their care because hospitals had deemed them to be beyond the help of psychiatric medicine. The PSW working in the field of local authority community care, claimed one *BJPSW* article from 1960, was 'likely to find that a high proportion of "hopeless" cases will come her way – semi-stabilised psychotics, chronics of all descriptions, psychopaths, epileptics, dullards – until the local authority office may even be regarded as some sort of benevolent dustbin.'³⁶

Michael Power, who worked for a local authority, complained that it was difficult for relatives 'to understand intellectually and accept emotionally the limitations of psychiatry, because of a natural tendency to regard specialists and hospitals as omnipotent and refuse to accept knowledge as limited and incomplete.' Nevertheless, he believed that there was often much that could be done to help such people, 'but socially rather than medically'.³⁷ Power, and other PSWs working in this field, developed a model of psychiatric social treatment that aimed to build on what was healthy within their clients by adjusting their social surroundings and interpersonal relations. They described how such an approach enabled them to enhance the lives of people with enduring mental health problems, many of whom had been discarded by psychiatrists as beyond the help of medical treatment, and to challenge the efficacy of a medical approach that did not consider people's social needs and their lives within a community.

Describing her work with clients diagnosed with paranoid schizophrenia in the community, Margaret Ferard, who was employed by a psychiatric hospital, coined the phrase 'psychiatric social treatment', to distinguish her work from psychiatric treatment carried out primarily from a medical standpoint.³⁸ She argued that if a PSW was in possession of a professional skill that she 'consciously employs with a therapeutic aim, it must logically follow that she is in fact carrying out treatment'. In contrast to the rationale underpinning physical treatments which aimed to cure incipient cases, Ferard defined the objective of such treatment as 'less ambitious, frankly palliative', designed to help 'the patient to fit into the community as well as possible in spite of his symptoms'.³⁹ Ferard focused on assessing and optimising her clients' degree of mental health, instead of concentrating on their illness so that she might enable her clients to adjust to society. To prevent the family's anxieties from damaging the social adjustment of her cases, Ferard found herself acting as a 'safety valve' for both client and family.⁴⁰ By focusing on

³⁶K. Iolo Jones and P.M. Hammond, 'The Boundaries of Training', *BJPSW*, 5, 4 (1960), 172–7: 173–4.

³⁷M. Power, 'Community Care – A New Service', *BJPSW*, 3, 3 (1956), 4–10: 7.

³⁸M.L. Ferard, 'Notes on the Psychiatric Social Treatment of Mental Hospital Patients: Four Paranoid Schizophrenics', *BJPSW*, 1, 1 (1947), 45–56: 45. Ferard subsequently took up a post in the London

Family Welfare Association as a consultant supervisor. See M. Ferard, 'Psychiatric Social Work and Social Casework in Other Fields: II', in E.M. Goldberg, *et al.* (eds), *The Boundaries of Casework: A Report on a Residential Course Held by the APSW Leicester, 1956*, (London: APSW, 1959), 16–21.

³⁹*Ibid.*, 55–6.

⁴⁰*Ibid.*, 48.

capabilities rather than symptoms, Ferard was able to assist her clients to gain employment, and consequently, more independence.⁴¹

PSW Eugene Heimler developed Ferard's emphasis on maximising the healthy aspects of her cases and restoring their social functioning further. Witnessing at first hand how a sense of futility and purposeless had destroyed people's mental health while a prisoner at Auschwitz, Buchenwald and Troglitz, Heimler wondered if mental distress could be alleviated if people were given a sense of purpose.⁴² He sought to adjust the environment to suit individuals, arguing that even people with apparently crippling delusions could lead normal lives if given conditions that suited them.⁴³ Heimler drew on psychoanalytic theory to argue that the present could be utilised as a therapeutic tool to induce people to adopt a new pattern of functioning which would assist them to feel differently about the past, explaining 'satisfaction can alleviate past frustrations'.⁴⁴ Heimler extended his analysis to a study of the relationship between an individual's satisfaction levels and their ability to function socially. He recognised that social isolation, prevalent amongst the elderly, might increase an individual's sense of purposelessness and induce mental distress. Heimler discussed the case of Mrs Smith, a widow who had derived satisfaction from bringing up her children and caring for her husband, until her children had left home and her husband died:

Mrs Smith – now in her seventies – had nothing to do but sit by her window and wait for her children to visit her. As she had lost all sense of purpose, her routine broke down. . . she neglected herself and was generally careless... Mrs Smith was admitted to an old people's home where her condition deteriorated. Away from her familiar way of life and with no interests to occupy her time, her imagination soon got the better of her. She began to hear voices and suffer from hallucinations about the past. Gradually, she became more and more depressed and finally had to be admitted to a mental hospital, where she died.⁴⁵

Convinced that a sense of futility caused people to breakdown unless counterbalanced by their satisfactions in life, Heimler created a Social Function Scale test. This measured levels of satisfaction in the fields of family relationships, friendships, work and hobbies, sexual satisfaction and financial security. Low satisfaction level scores indicated an individual's inability to function adequately in a social setting.⁴⁶ By embracing the ability of the present to change the way a person may feel about negative events in the past, Heimler adopted a more therapeutically optimistic attitude than Ferard's 'palliative' approach, attempting to sever the link between mental illness and the ability of an individual to function adequately in their community. As Heimler explained to journalist Christopher Driver, 'people who were revealed to be hopelessly neurotic when scored by Doctor Eysenck's Maudsley personality inventory could score correspondingly high

⁴¹The work undertaken by Ferard and Eugene Heimler to enable people with mental health problems to gain employment is discussed in Vicky Long, "'A Satisfactory Job is the Best Psychotherapist': Employment and Mental Health, 1939–60", in Pamela Dale and Joseph Melling (eds), *Mental Illness and Learning Disability: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), 179–99.

⁴²Discussed in Eugene Heimler, *Mental Illness and Social Work* (Harmondsworth: Pelican, 1969), 107–10; and Eugene Heimler, *The Healing Echo* (London: Souvenir Press, 1985), 13–16.

⁴³C. Driver, 'Concentration Camp Graduate', *The Guardian*, 8 April 1961, 4.

⁴⁴Heimler, *Mental Illness*, *op. cit.* (note 42), 119.

⁴⁵*Ibid.*, 54–5.

⁴⁶*Ibid.*, 122–9.

on “social functioning”. Their satisfactions, it seemed, could counterbalance their sickness.⁴⁷

The Objectives of ‘Physical’ and ‘Social’ Treatments: Antithetical or Complementary?

The physical and social treatment approaches advocated by psychiatrists and PSWs were premised on apparently antithetical conceptualisations of disease causation. Many psychiatrists in the 1940s and 1950s believed that mental illness had a biological aetiology and deployed physical treatments which targeted the individual patient as a clinical entity abstracted from his or her social environment. By contrast, most PSWs believed that mental illness could only be alleviated if social and environmental circumstances were addressed. Thus, the PSW studied the individual patient in the context of their family and social environment and advocated ‘social’ psychiatric treatment.

In some respects, this was a false dichotomy. Not all psychiatrists, after all, embraced the biological turn in psychiatric practice. Psychiatrists and psychoanalysts seeking to rehabilitate and re-socialise soldiers suffering from neurosis at Mill Hill and Northfield military hospitals experimented with group treatment methods, utilising interpersonal relations and the social environment of the hospital as a therapeutic tool. After the cessation of the Second World War, some hospitals adopted this therapeutic approach, leading to the development of the concept of the therapeutic community.⁴⁸ In practice, social and physical approaches to treatment frequently co-existed within hospitals, and the desirable clinical outcomes of physical and social treatments were often similar. Describing how he had transformed Claybury from a traditional authoritarian hospital into a therapeutic community, Dennis Martin explained that he was opposed not to physical treatments *per se* but to their deployment for controlling disturbed patients. He felt that physical and psychological treatments could profitably be combined and went on to suggest that many hospitals had neglected psychological or social treatments simply because they lacked sufficient doctors to carry out such treatment on an individual basis. For Martin, the therapeutic community was the perfect mechanism to provide psychotherapeutic treatment to the entire patient population without necessitating a rise in staff numbers, offering a form of mass psychotherapy.⁴⁹

Moreover, the first PSWs to qualify in the 1930s and 1940s aimed not to fulfil the individual needs of their clients, but to manage and reshape individuals so that they con-

⁴⁷C. Driver, ‘Testing Social Normality’, *The Guardian*, 28 July 1964, 6–7.

⁴⁸See Tom Harrison and David Clarke, ‘The Northfield Experiment’, *British Journal of Psychiatry*, 160 (1992), 698–708; John A. Mills and Tom Harrison, ‘John Rickman, Wilfred Ruprecht Bion, and the Origins of the Therapeutic Community’, *History of Psychology*, 10 (2007), 22–43; Stuart Whiteley, ‘The Evolution of the Therapeutic Community’, *Psychiatric Quarterly*, 75 (2004), 233–48; D.W. Millard, ‘Maxwell Jones and the Therapeutic Community’, in Berrios and Freeman (eds), *150 Years of British Psychiatry, Volume II: The*

Aftermath, (London: Athlone, 1996), 581–604; Maxwell Jones, *Social Psychiatry in Practice: The Idea of the Therapeutic Community* (Harmondsworth: Pelican, 1968). Another initiative that stemmed from the experiences of the War was the Social After-Care Service. Operated by the National Association of Mental Health, the Service attempted to facilitate the social adjustment of ex-service personnel who had been discharged on psychiatric grounds. See Toms, *op. cit.* (note 8), 132–3.

⁴⁹Denis V. Martin, *Adventures in Psychiatry: Social Change in a Mental Hospital* (Oxford: Bruno Cassirer, 1962), 140–2

tributed to society: understanding the individual client meant understanding their individualised failings. In this sense, their work reflected a broader willingness to utilise the human sciences to understand, manage and enhance the behaviour of individuals and society.⁵⁰ The American pioneer of psychiatric social work, Mary Jarrett, believed that PSWs were aptly trained to help maladjusted individuals adapt to the workplace. Mental hygiene in industry, she wrote, attempted to attain the ‘scientific large-scale production of individualisation’.⁵¹ Ultimately, the emerging profession of scientific management curbed this initiative and consequently PSWs were never employed in British industry;⁵² nevertheless, early British PSWs attempted to instil normative behaviour, seeing it as their responsibility to adjust individuals and families believed to be deviant to social norms. In 1932, for example, one such case, R D, was described as ‘essentially capable of contributing, as an intelligent and responsible citizen, to the community on which he has so long parasitically depended.’⁵³

Throughout the 1940s and early 1950s, many PSWs had been careful to balance the needs of their clients with the perceived interests of society. E. L. Thomas warned fellow PSWs in 1950 that ‘concern for a patient’s optimal readjustment cannot be pursued to the point of jeopardising the welfare of others.’⁵⁴ Molly Harrington, who worked in a Borstal institution, believed that PSWs should adopt the stance of a caseworker, not a reformer and accept ‘the present stage of social opinion and, above all, of the work of the people operating the system’.⁵⁵ This authoritarian stance was reflected in the Younghusband Report, which claimed that the PSW understood ‘deviations from the normal’ and used ‘a professional relationship in a disciplined way’ to carry out treatment.⁵⁶ While PSWs recognised the individuality of their cases, they nevertheless considered it their role to adjust their clients to society. Indeed, Eliot Slater neatly turned the table on critics of physical therapies to suggest that psychosocial approaches to mental illness failed to individualise the patient. Many such practitioners, he argued ‘are totally misled by bogus ideas’ getting their information from ‘social knowledge which is knowledge about societies and groups, not about individuals.’⁵⁷

Attempting to adjust the individual suffering from mental illness so that he or she conformed to their social environment was a long-standing objective in mental healthcare and transcended the perceived boundaries of physical and social treatment

⁵⁰For a broad overview of the interaction of politics and human sciences in understanding and managing individuals and society, see Greg Eghigian, Andreas Killen and Christine Leuenberger, ‘The Self as Project: Politics and the Human Sciences in the Twentieth Century’, *Osiris*, 22 (2007), 1–25; the applied use of psychological ideas to create governable subjects is explored in Rose, *op. cit.* (note 8).

⁵¹Mary C. Jarrett, ‘The Practical Value of Mental Hygiene in Industry’, *Hospital Social Services*, 3 (1921), 361–5; 364 cited in 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: 434.

⁵²*Ibid.*

⁵³APSW, *Psychiatric Social Work and the Family by the APSW. Part II: Illustrative Material: A Study in Preparation for the Second International Conference on Social Work* (London: APSW, 1932), 7.

⁵⁴E.L. Thomas and K.M. Lewis, ‘Papers on the Role of the PSW Given to the AGM of the Psychiatric Session of the BMA in 1950’, *BJPSW*, 1, 4 (1950), 18–24: 22.

⁵⁵M. Harrington, ‘Psychiatric Social Work in a Borstal Institution’, *BJPSW*, 1, 4 (1950), 40–2: 40.

⁵⁶*Report of the Working Party on Social Workers*, *op. cit.* (note 14), 128.

⁵⁷E. Slater, interviewed by B. Barraclough in 1981, in Greg Wilkinson (ed.), *Talking About Psychiatry*, (London: Royal College of Psychiatry, 1993), 12.

approaches.⁵⁸ As Pressman argued, many psychiatrists who advocated physical treatments also sought to re-socialise patients they viewed as maladjusted or maladapted, measuring success in terms of a patient's conformity or adjustment to hospital and ward routines.⁵⁹ The therapeutic approaches may have been at opposite poles, but the objective was virtually identical. The social approaches advocated by PSWs were thus not unique within the field of psychiatric practice but were out of step with the dominant therapeutic trends of the 1940s and 1950: the effort to assimilate mental illness with physical illness and to transform asylums into hospitals through the use of physical treatments.

By the late 1950s and early 1960s, PSWs began to focus on the societal problems that might block an individual's adjustment and integration into society. In 1960, the same year that the Younghusband Report was published, the APSW described psychiatric social work in a career pamphlet as 'a branch of social casework which is concerned with helping disturbed people and society adapt themselves to one another'.⁶⁰ As social therapist, the PSW's role was now to mediate between the interests of the private individual and the wider public. In 1963, the APSW launched a sustained attack on the idea that the individual experiencing mental distress should strive to adapt him or herself to society. Urging her colleagues to adopt the role of reformer, APSW Chairman Irene Spackman asserted that casework 'is not a panacea for all social ills'.⁶¹ A report of the APSW's conference in *New Society* explained:

Social workers are being asked to help people adjust to society in cases where society should be doing a better job for the individual.... When the welfare services fail, social workers are expected to make life bearable, but it is housing, National Assistance and other national needs which are often unfulfilled. ... It can be said that adjustment is necessary because reality has to be accepted, but the social workers would like to do a little adjustment of reality and society for a change.⁶²

While William Sargant complacently relegated psychiatric social work to the dustbin of history in his 1967 memoir, changes in mental healthcare policy and broader cultural developments had led to a reassessment of the place of social therapies in psychiatric practice. In 1961, the government announced proposals for a reduction in the number of psychiatric hospital beds. As the government implemented a policy of hospital closure and sought to transfer services into the community, attention began to focus on the difficulties posed by long-stay hospital patients. Physical treatments, which aimed to facilitate the management of patients in overcrowded hospitals by inducing calmer behaviour, were of limited use for practitioners seeking to deinstitutionalise long-stay patients.

⁵⁸Its roots can be traced back to the moral therapy approach adopted at the York Retreat, which framed patients as wayward children and sought to use social relationships to re-socialise patients to normal patterns of behaviour. Stressing the increasingly disciplinary character of this approach, Anne Digby suggested that moral management displaced moral therapy. See Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1996–1914* (Cambridge: Cambridge University Press, 1985), 33–87.

⁵⁹Pressman, *op. cit.* (note 34), 220–31.

⁶⁰APSW, *A Career as a Psychiatric Social Worker* (London: APSW, 1960), 1.

⁶¹APSW Archive, MSS.378/2/1:29: 'APSW Annual Report 1963', 7.

⁶²APSW Archive, MSS.378/APSW/P/14/4:120. From unnamed, undated paper, 'Social Work – Who's Out of Step?' Judging from the phrasing of this article, it appears to be the one sent by PSW Jean Nursten to the editor of *New Society* reporting on the APSW conference 'Psychiatric Social Work: Developments in Training and Practice' held in Manchester from 8–13 September 1963. Nursten entitled her piece 'A Question of Adjustment': APSW Press Correspondence 1955–1965, MSS.378/APSW/P/14/3:106a.

Social psychiatrists, such as John Wing, argued that such patients could only be socially reintegrated through a programme of rehabilitation which focused on employment, family and social functioning.⁶³ The medical psychiatric approach also came under attack from the anti-psychiatry movement, informed by broader social and cultural trends that favoured a social approach to mental disorder.⁶⁴

Joshua Bierer, who founded the Marlborough Day Hospital, argued that many mental disorders involved the breakdown of an individual's socialisation skills within the family, the workplace or general interpersonal relationships.⁶⁵ He believed that mental hospitals contributed towards the de-socialisation of those who experienced mental distress and criticised the increasing specialisation within medicine and psychiatry:

We know more and more about less and less! There is, however, a counter-movement towards specialisation, one which attempts to look at the total patient; but even this is insufficient in our estimation. Considering the total individual is not enough. When working with patients, all factors are important – cultural factors, constitutional factors, everything which has a bearing on interpersonal relations.⁶⁶

However, the growing appeal of social psychiatry and the shift in government policy was not matched by a commensurate investment in training specialised personnel or providing community-based services. In 1972, the Certificate of Qualification in Social Work, introduced to train a new breed of generic social worker, replaced prior specialist training schemes for different branches of social work including psychiatric social work. Drawing on interviews with health service users, Peter Barham and Robert Hayward demonstrated how the shortfall of specialised personnel and services affected the lives of people who experienced severe mental illness in the 1980s and 1990s.⁶⁷ Vaughan, for example, had lost possession of his flat during the four months he had been in hospital, but his doctor appeared unable or unwilling to recognise how Vaughan's medical and social problems interacted. 'I said I had nowhere to go', Vaughan recollected, to which his doctor responded 'well, there's nothing I can do, you're better now and you can go home'.⁶⁸ Another interviewee, Henry, was unemployed and lived in a council flat at the margins of a town. Henry described how he believed that his diagnosis of

⁶³See, for example, John Kenneth Wing, Douglas Harley Bennett and John Denham, *The Industrial Rehabilitation of Long-Stay Schizophrenic Patients: A Study of 45 Patients at an Industrial Rehabilitation Unit* (London: Medical Research Council, 1964); John Kenneth Wing and Brenda Morris, *Handbook of Psychiatric Rehabilitation Practice* (Oxford: Oxford University Press, 1981).

⁶⁴Themes developed by a number of contributors to Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam: Rodopi, 1998), especially Colin Jones, 'Raising the Anti: Jan Foudraine, Ronald Laing and Anti-Psychiatry', in *idem*, 283–94.

⁶⁵For a critical overview of Bierer's career, see Liam Clarke, 'Joshua Bierer: Striving for Power', *History of Psychiatry*, 8 (1997), 319–32.

⁶⁶Joshua Bierer and Richard I. Evans, *Innovations in Social Psychiatry: A Social Psychological Perspective through Discourse* (London: Avenue Publishing, 1969), 27.

⁶⁷Peter Barham, *Schizophrenia and Human Value: Chronic Schizophrenia, Science and Society*, 2nd edn (London: Free Association Books, 1993); Peter Barham and Robert Hayward, *Relocating Madness: From the Mental Patient to the Person*, 2nd edn (London: Free Association Books, 1995); Peter Barham, *Closing the Asylum: The Mental Patient in Modern Society*, 2nd edn (London: Penguin, 1997). On the failure to develop community services, see Jones, *op. cit.* (note 21), 181–96.

⁶⁸Barham, *Closing the Asylum*, *op. cit.* (note 67), 54

schizophrenia would 'always make me a second-class citizen', despite the fact that his symptoms were largely under control.⁶⁹ Henry's account, Barham and Hayward asserted, illustrates 'not the *natural* consequences of mental illness, but the *social* consequences of becoming mentally ill. . . the social pressures and constraints that have turned him into a person devoid of purpose and worth.'⁷⁰

Conclusion: Treatment, Care, Recovery and Cure

Addressing a meeting of the APSW in 1959, child psychiatrist Tom Ratcliffe admonished his listeners for transcending their auxiliary role to provide interpretative analytical casework.⁷¹ There was a danger, he claimed, that the therapeutic approaches adopted by PSWs could become 'governed more by the training level – and dare we say the professional ambitions – of the therapist or caseworker, than by the level of therapy which is most appropriate to the client's needs and capacity.'⁷² PSWs, Ratcliffe implied, were medical auxiliaries responsible for providing care, not therapists who provided treatment. Assertions that PSWs were practising 'psychiatric social treatment' could be read as an attempt to challenge the status of medical auxiliaries and to substantiate claims to professional expertise and status.⁷³

For psychiatrists, Andrew Scull has argued, the development and use of physical treatments was linked as much to questions of professional claims to expert knowledge, as to scientific advances. Physical treatments, in short, embodied expert psychiatric knowledge and helped to sustain the status of the profession.⁷⁴ Shulamit Ramon argued that PSWs were comfortable with their status as medical auxiliaries, followed the conceptual framework adopted by psychiatrists, adopted a pessimistic approach to working with adults, and embraced physical interventions with enthusiasm, but an examination of the APSW archives demonstrates that this was simply not the case.⁷⁵

⁶⁹Barham and Hayward, *op. cit.* (note 67), 76.

⁷⁰*Ibid.*, 77.

⁷¹Ratcliffe authored *The Child and Reality: Lectures by a Child Psychiatrist* (London: Allen & Unwin, 1967) and held posts at the Nottingham City Mental Hospital and Nottingham Children's Hospital.

⁷²T.A. Ratcliffe, 'Relationship Therapy and Casework', *BJPSW*, 5, 1 (1959), 4–9: 4.

⁷³PSWs can be seen as belonging to the group of occupations working in the fields of health, education and social welfare that Chris Nottingham has recently described as 'insecure professionals', whose claims to professional status on the grounds of unique professional skills and knowledge, verified through qualifications, were vigorously challenged. See Chris Nottingham, 'The Rise of the Insecure Professionals', *International Review of Social History*, 52 (2007), 445–75. Similarly, Pamela Dale has deployed the term 'lay professionals' in her analysis, see Pamela Dale, 'Tension in the Voluntary-Statutory Alliance: "Lay Professionals" and the Planning and Delivery of Mental Deficiency Services, 1917–45', in Dale and

Melling, *op. cit.* (note 41), 154–78. Vicky Long has explored how discussion within and between different occupational and voluntary groups within the field of mental health regarding the nature of mental illness and its treatment was shaped by differing levels of power and influence. See Long, 'Changing Public Representations', *op. cit.* (note 7).

⁷⁴Andrew Scull, 'Somatic Treatments and the Historiography of Psychiatry', *History of Psychiatry*, 5 (1994), 1–12. Lindsay Prior has also pointed to the interrelationship between professionalisation and practice, arguing that psychiatry produced beliefs and objects such as asylums and disease classifications that defined the nature of mental illness and led to mental illness being organised in a particular way, and that these organisational structures then reinforced the representations that created them in the first place. See Lindsay Prior, *The Social Organization of Mental Illness* (London: Sage, 1993).

⁷⁵Ramon, *op. cit.* (note 25), 206–19. Ramon drew on the *BJPSW* to evidence her argument but does not

While some of the first PSWs to qualify suggested that the PSW could assist psychiatrists, the APSW very rapidly sought to define the PSW's distinctive sphere of expertise. In 1951, for example, the APSW successfully resisted suggestions that PSWs should be registered as medical auxiliaries, claiming that such a designation would be inappropriate, as PSWs were 'social workers with roots in the social sciences'.⁷⁶ Five years later, the APSW attacked the British Medical Association for evidence it had given to the Working Party on Social Workers. 'When the doctors emphasise so much "a real sense of vocation" and so little the acquisition of skills, they are perpetuating in the social field a state of affairs which would not be accepted in their own profession.'⁷⁷

Within psychiatric social work, child guidance had long been seen as the most prestigious field of work because the PSW could claim to be undertaking psychotherapeutic treatment with the mother of the child, often portrayed as a patient in her own right. It was in the unpromising environment of local authority mental health departments and psychiatric hospital work that PSWs moved beyond an attempt to adjust individuals to society to identify how social factors constrained recovery. In these fields, PSWs found themselves working with clients perceived to be 'incurable': their work was conceived of as palliative care, not active treatment. *BJPSW* articles provide an insight into how PSWs working in this field sought to challenge these distinctions between care, cure and treatment. Given the relatively small number of PSWs practising, the low circulation of the *BJPSW*, and the difficulty of ascertaining how representative individual contributors were of practice throughout the profession, these initiatives probably had little impact in practice.

Recalling his work with William Mayer-Gross in the late 1940s and early 1950s, PSW Cyril Greenland described the scepticism he felt when Mayer-Gross expressed his belief that 'a cure for schizophrenia was imminent'.⁷⁸ The tantalising promise that the new physical therapies could cure mental illness proved a hollow illusion: although advocates of physical treatments, such as William Sargant, emphasised their curative powers, many patients were, in practice, described as improved or relieved after physical treatments. Psychiatrists made confident assertions regarding the somatic aetiology of mental illnesses despite having failed to identify an underlying biological cause: they devised physical treatments in a crude, empirical fashion and applied treatments in an equally haphazard fashion. Indeed, many psychiatrists rationalised risky procedures of often limited or doubtful therapeutic value when treating chronic patients.⁷⁹ The reports of PSWs

appear to have used the APSW archives or other publications produced by PSWs.

⁷⁶*Report of the Committee on Medical Auxiliaries* (1951), Cmd 8188. APSW Archive, MSS.378/APSW/2/1:18, 'APSW Annual Report 1952-1953', 6. There are clearly strong parallels here with the professional aspirations of medical social workers, another distinct group within social work, which also had to negotiate its relationship to both doctors and other social workers. See Chris Nottingham and Rona Dougall, 'A Close and Practical Association with the Medical Profession: Scottish Medical Social Workers and Social

Medicine, 1940-1975', *Medical History*, 51, 3 (2007), 309-36.

⁷⁷Mary A. Lane and H.E. Howarth, 'Social Workers', *British Medical Journal*, 4983, supplement 2685 (1956), 5-6: 6.

⁷⁸Greenland, *op. cit.* (note 26), 469.

⁷⁹Jack Pressman argued that psychosurgery was viewed as a 'salvage' operation, seen as particularly suitable for patients with 'nothing to lose': Pressman, *op. cit.* (note 34), 199-207. Similarly, Andrew Scull's study of Henry Cotton reveals that Cotton justified his riskiest surgical interventions on the grounds that they were a 'last resort' for chronic cases (although

'Often there is a Good Deal to be Done'

working on the frontline of physical therapies in psychiatric hospitals illustrate that physical therapies had failed to remove the problems posed by enduring mental illness.

The 'psychiatric social treatment' approach advocated by Margaret Ferard vacillated uneasily between despondency and optimism. We might censure the pessimistic and, at times, disciplinary tone adopted in the articles written by PSWs working with people within hospitals or those discharged to the community, and suggest that PSWs perpetuated the image of the chronic, damaged mental patient and maintained traditional hierarchies of power. Alternatively, we could interpret 'psychiatric social treatment' as an inventive attempt to alleviate the difficulties experienced by people with enduring mental illness, whose symptoms had proved intractable in the face of physical therapies and whose needs were frequently neglected or marginalised by a paradigm of psychiatric practice keen to emphasise the curability of mental illness.

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subsequent analysis of Cotton's records would reveal that a much broader cohort of patients were operated on); see Andrew Scull, *Madhouse: A Tragic Tale of*

Megalomania and Modern Medicine (New Haven: Yale University Press, 2007), 263–5.