Med. Hist. (2016), *vol.* 60(1), *pp.* 67–86. doi:10.1017/mdh.2015.69

Constructing Patient Stories: 'Dynamic' Case Notes and Clinical Encounters at Glasgow's Gartnavel Mental Hospital, 1921–32

HAZEL MORRISON *

Independent researcher formerly affiliated with University of Glasgow

Abstract: This article contextualises the production of patient records at Glasgow's Gartnavel Mental Hospital between 1921 and 1932. Following his appointment as asylum superintendent in 1921, psychiatrist David Kennedy Henderson sought to introduce a so-called dynamic approach to mental health care. He did so, primarily, by encouraging patients to reveal their inner lives through their own language and own understanding of their illness. To this effect, Henderson implemented several techniques devised to gather as much information as possible about patients. He notably established routine 'staff meetings' in which a psychiatrist directed questions towards a patient while a stenographer recorded word-for-word the conversation that passed between the two parties. As a result, the records compiled at Gartnavel under Henderson's guidance offer a unique window into the various strategies deployed by patients, but also allow physicians and hospital staff to negotiate their place amidst these clinical encounters. In this paper, I analyse the production of patient narratives in these materials. The article begins with Henderson's articulation of his 'dynamic' psychotherapeutic method, before proceeding to an in-depth hermeneutic investigation into samples of Gartnavel's case notes and staff meeting transcripts. In the process, patient–psychiatrist relationships are revealed to be mutually dependent and interrelated subjects of historical enquiry rather than as distinct entities. This study highlights the multi-vocal nature of the construction of stories 'from below' and interrogates their subsequent appropriation by historians.

Keywords: Gartnavel Mental Hospital, Glasgow, Case notes, David Kennedy Henderson, Patient's voice, History of psychiatry

* Email address for correspondence: hazel.c.morrison@googlemail.com

In support of the doctoral research on which this article is based, I acknowledge the assistance of Chris Philo, Malcolm Nicolson and Cheryl McGeachan, as well as the Arts and Humanities Research Council. For giving me insight into the sights and sounds of the staff meeting, I thank psychiatrist Ian Smith. Thanks are also due to Alistair Tough at the NHS Greater Glasgow and Clyde archives for his help with archival materials. For tirelessly advising on this article, I am grateful to Aude Fauvel, Alexandra Bacopoulos-Viau and to three anonymous reviewers.

The Patient's View

In 1985, Roy Porter's seminal article on 'The Patient's View' confronted the notion that 'the history of healing is par excellence the history of doctors.' Antithetical to a physician-centred approach was Porter's call to do 'history from below' and thereby also focus on the other half of the doctor–patient dyad.[1] 'At present', Porter declared, 'we remain ... profoundly ignorant of how ordinary people in the past have actually regarded health and sickness'. An alternative vision for the history of medicine would be 'written from the patient's point of view'.[2] Thirty years on, there remains a concerted effort to elucidate the sufferer's role in the history of health and healing. Recent developments, however, most notably in the history of psychiatry, reveal a groundswell of dissatisfaction among scholars who argue that the historian 'can no longer be content with describing the theories and practices of the psychiatrist, or, inversely, the subjective experience of the patient' alone.[3] Rather, they claim, researchers need to explore the interactive dimensions of the doctor–patient relationship – and beyond. To facilitate this shift in focus from a history of patients to a history of these complex clinical dynamics, scholars have increasingly (re)turned to the archives. For historians of psychiatry, specifically, patient case notes have long been recognised as a potentially fruitful archival resource.[4]

In this paper I chart my own engagement with the patient records of Glasgow's Gartnavel Mental Hospital by focusing on Superintendent Dr David Kennedy Henderson and his introduction to Gartnavel of a so-called 'dynamic' approach to mental health care in the 1920s.[5] In order to appreciate the significance of such records, the article begins with Henderson's articulation of his psychotherapeutic method, before proceeding to an in-depth hermeneutic investigation into samples of Gartnavel's case notes. In the process, I explore patient–psychiatrist relationships, not as distinct entities, but as mutually dependent and interrelated subjects of historical enquiry. These materials reveal a complex and multi-faceted clinical picture that involves various strategies of negotiation deployed by all members of the clinical encounter. Although Henderson promoted 'sensitivity to the "stories"',[6] patients' compliance or resistance was based largely on their gender, social class and admission status. These elements, which often determined their willingness to

[1] Roy Porter, 'The Patient's View, Doing Medical History from Below', *Theory and Society*, 14, 2 (1985), 175.
[2] Porter, *op. cit.* (note 1), 176.
[3] Mikkel Borch-Jacobsen, *Making Minds and Madness. From Hysteria to Depression* (Cambridge: Cambridge University Press, 2009), 8–9. For complementary accounts, see also, eg., Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient and the Family in England*, 1820–60 (Berkeley, CA: University of California Press, 2006); Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke and New York: Palgrave Macmillan, 2004).
[4] Donald P. Spence, 'Narrative Smoothing and Clinical Wisdom', in Theodore R. Sarbin (ed.), *Narrative Psychology, the Storied Nature of Human Conduct* (New York: Praeger Publications, 1986), 215; Petra Peckl, 'What the patient records reveal: reassessing the treatment of "war neurotics" in Germany (1914–18)', in Hans-Georg Hofer, Cay-Ruediger Pruell and Wolfgang U. Eckart (eds), *War, Trauma and Medicine in Germany and Central Europe (1914–39)* (Freiburg: Centaurus, 2011), 148; Stefanie Caroline Linden and Edgar Jones, "'Shell shock" Revisited: An Examination of the Case Records of the National Hospital London', *Medical History*, 58, 4 (2014), 522. Jonathan Andrews examined the Gartnavel case notes in the nineteenth century: Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11, 2 (1998), 255–81.
[5] This piece is based on a larger body of work in which I analysed over sixty of Gartnavel's patient case notes. See Hazel Margaret Catherine Morrison, 'Unearthing the "Clinical Encounter": Gartnavel Mental Hospital, 1921–32' (PhD diss.: University of Glasgow, 2014).
[6] This expression is used by psychiatrist Adolf Meyer in a series of lectures that he gave in 1931 and which were later compiled into a book: Adolf Meyer, 'Therapy', in Eunice Winters and Anna Mae Bowers (eds), *Psychobiology, a Science of Man* (Illinois: Charles C. Thomas, 1957), 157–60. Henderson appropriated it in his own textbook: David Kennedy Henderson and Robert Dick Gillespie, *A Text-Book of Psychiatry for Patients and Practitioners*, 2nd edn (Edinburgh: Humphrey Milford, Oxford University Press, 1932), 76.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

tell their stories, directly or indirectly, made their way into the case notes. Therefore, Gartnavel's patient records involve processes of construction and reconstruction at various levels by patients, psychiatrists, medical staff and historians alike.

Henderson, Meyer and the Introduction of 'Dynamic' Case Notes

Dr David Kennedy Henderson (1884–1965), Gartnavel's superintendent during the period of interest (1921–32), trained under some of the most eminent psychiatrists of his time. These included Thomas Clouston in Edinburgh, Adolf Meyer in Baltimore, August Hoch in New York and Emil Kraepelin in Munich. Between 1908 and 1919, he worked at the Royal Edinburgh Asylum, the Pathological Laboratories of the New York State Hospitals, the Nussbaumstrasse Clinic in Munich, the Henry Phipps Psychiatric Clinic in Baltimore, the Lord Derby War Hospital in Lancashire and Gartnavel Mental Hospital in Glasgow, publishing scholarly articles on such topics as cerebral syphilis, war psychosis, and catatonia.[7] Entering the profession at a time of scepticism regarding nascent psychoanalytic theories and Kraepelinian classificatory systems, Henderson's blend of Kraepelinian, Freudian, and Meyerian teachings was in many ways pioneering. 'Long before any other centre in Great Britain began to stir in response to the remarkable things which were being done on the North American continent', wrote Henderson's colleague Donald Ewan Cameron in 1965, '[Henderson] began to send his young men to train with Adolf Meyer'.[8] The influence of Meyer – who by the inter-war years had become a leading figure of North American psychiatric thought – played a particularly significant role in bringing new therapeutic practices to Britain. Specifically, it led to the introduction at Gartnavel of what Meyer and Henderson called a 'dynamic' psychotherapeutic approach.[9]

Meyer, hailed during his lifetime as the 'Dean of American Psychiatry', was instrumental in shaping and promoting a new conception of the mind in early twentieth-century North America.[10] A Swiss-born émigré, Meyer came to reject the rigid somaticism of late nineteenth-century psychiatry as it was then practised in North America.[11] Rather, he saw mental illness as the 'cumulative result of unhealthy reactions of the individual mind to its [physical and social] environment'; he thus replaced the concept of mental illness as *disease* with that of mental illness as a *reaction type* 'that required both physical and psychological explanation'.[12] It was during Henderson's early years of training under

[7] David Kennedy Henderson, 'The Diagnosis of Cerebral Syphilis', *Review of Neurology and Psychiatry*, 9 (1911), 241–51; David Kennedy Henderson, 'War Psychoses – Dementia Praecox in War Time', Reprinted from *Review of Neurology and Psychiatry*, Nov.–Dec. 1918 in 'Files and Paper of Physician Superintendents GB812 HB13/11 NHSGGCA', 2–3; David Kennedy Henderson, 'Catatonia as a Type of Mental Reaction', *The British Journal of Psychiatry*, 62 (1916), 556–72.

[8] Donald Ewan Cameron, 'In Memorium, David Kennedy Henderson (1884–1965)', *American Journal of Psychiatry*, 122, 4 (1965), 468.

[9] For the uses of the term 'dynamic' in North American and European contexts at that period, see Edwin R. Wallace, 'Historiography. Philosophy and Methodology of History, with Special Emphasis on Medicine and Psychiatry; and an Appendix on "Historiography" as the History of History' in Edwin R. Wallace and John Gach (eds), *History of Psychiatry and Medical Psychology* (New York: Springer, 2008), 3. See also Henri F. Ellenberger, *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970) Chapter 10.

[10] Susan Lamb, *Pathologist of the Mind. Adolf Meyer and the Origins of American Psychiatry* (Baltimore: Johns Hopkins University Press, 2014).

[11] Nancy Tomes 'The Development of Clinical Psychology, Social Work, and Psychiatric Nursing: 1900–1980s', in Wallace and Gach (eds), *op. cit.* (note 9), 658.

[12] Duncan B. Double, 'Adolf Meyer's Psychobiology and the Challenge for Biomedicine', *Philosophy, Psychiatry, and Psychology*, 14, 4 (2007), 331–9.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Meyer, first in New York (1908–11) and later in Baltimore (1912–15), that he was taught to combine psychological studies of experience and individual subjectivity with pathological anatomy.[13] Surrounded by colleagues such as August Hoch, who pioneered North American personality studies in the early twentieth century, Henderson became engrossed in a field of research which took as its subject matter the relationship between patients' thoughts, feelings and the external world. The focus of this interrelationship was often to be ascertained through conversation with the patient. According to Meyer, '[t]he psychiatrist – the user of biography – must help the *person himself* . . . to restore . . . the capacity for self-regulation'. Here, the patient's '*own language*' and own understanding of his or her illness was used as the basis for any 'advice and further elucidation'.[14] In the wake of the psychoanalytic movement's increasing popularity both in the Continent and in North America, personality studies, dream analyses, word association tests and talking therapies became part of these psychiatrists' investigatory and therapeutic arsenal. Unlike Freud, however, Meyer taught his students and colleagues to desist from transforming patient stories into complex, theory-laden narratives. Rather, he advised that the psychiatrist use the patient's own story as the basis for therapeutic intervention. This would be achieved through trust and co-operation.

To transform individual stories into clinically 'objective' facts, Meyer's long-lasting contribution to psychiatry was to standardise methods of examination and case note-taking procedures.[15] All of the potentially relevant factors in a case were to be 'made objectively evident' through longitudinal studies of an individual's life history, recorded in 'uniform and systemic fashion'.[16] As Ruth Leys writes:

> [Meyer] provided his students with a basic outline to be followed, specifying the order of procedure . . . and . . . actual questions to be put to the patient, something that had been lacking in previous handbooks of psychiatry.[17]

Another novelty that Meyer introduced to North American institutions was the practice of holding so-called staff meetings, the proceedings of which were recorded by clinical stenographers. 'The art of history-taking', Henderson later observed when reflecting upon Meyer's teachings, was 'invaluable in relation to prognosis, diagnosis and treatment'.[18] Such methods became the cornerstone of North American psychiatric practice in the decades to come.[19]

The 'Dynamic' Case Note as Established at Gartnavel

Upon Henderson's promotion to physician-superintendent of Gartnavel Mental Hospital in 1921, he instigated new clinical practices based on Meyer's methods. Remarks, examinations, staff conferences, nursing reports, laboratory testing, diagnosis and prognosis; each formed a constituent element of the Meyerian-inspired dynamic case note at Gartnavel. Leaning heavily upon Meyer's 1918 case-taking guides and those of

[13] Ruth Leys, 'Types of One: Adolf Meyer's Life Chart and the Representation of Individuality', *Representations*, 34 (Spring 1991), 2–4.
[14] Meyer, *op. cit.* (note 6), 158, 164; emphasis in original.
[15] Adolf Meyer, 'A Few Remarks Concerning the Organization of the Medical Work in Large Hospitals for the Insane', in Eunice Winters (ed.), *The Collected Papers of Adolf Meyer, Vol. II. Psychiatry* (Baltimore: The Johns Hopkins Press, 1951), 83–4.
[16] *Ibid.*, 164.
[17] Leys, *op. cit.* (note 13), 5–6.
[18] David Kennedy Henderson, 'Introduction' in Winters (ed.), *op. cit.* (note 15), xii.
[19] As Susan Lamb makes clear, the case note record was the 'object of study' par excellence, as it 'objectified experience and embodied medical authority and scientific precision'. Lamb, *op. cit.* (note 10), 1–4; 169.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

his American colleague, Dr George Hughes Kirby,[20] Henderson typically divided the Gartnavel patient records in tripartite fashion, consisting of the Anamnesis (personal history), the Physical Examination and the Mental Examination. The duty of writing case notes fell to clinical clerks and stenographers as well as more senior medical officers.[21] This, as we shall see, is not insignificant. The marks these authors made on the page are highly revelatory as to the processes of selection and interpretation by which medical knowledge was produced. Meyerian case-taking guides aimed to capture a 'live and continued' account of examinatory procedures.[22] This was achieved through the use of narrative stylistics and grammatical choices. Case notes include inverted commas, used to denote verbatim recordings of speech, while colons, dashes and question marks were used to highlight pauses, rhythms and silences that punctuated patients' spoken words. Brackets, used to insert the writer's own observations of tone, emotional content or actions that accompanied speech, add another layer of interpretative depth. All of this was ultimately intended to enable the psychiatrist to better understand the organic, as well as psychological, components of a patient's ills.

Meyer's teachings motivated Henderson to push Scottish psychiatry away from its former emphasis on the description of symptoms, classification and brain pathology, and towards the study of the individual's personality as a reaction to his or her environment.[23] Gartnavel's resident medical officers were encouraged to embrace the clinical teachings of Kraepelin, the personality studies of Meyer, August Hoch and George Amsden, and the 'stimulating'[24] work of Freud and Jung. Case notes reveal occasions where therapeutic interventions effectively took the form of talking and occupational therapies. Rejecting the seeming rigidity of somatic-pathological interpretations then largely prevalent in the British psychiatric profession, Henderson declared that 'general descriptions of clinical

[20] In 1921, the publication of Kirby's *Guides for History Taking and Clinical Examination of Psychiatric Cases* laid out the principles set by Adolf Meyer for the psychobiological analysis of psychiatric patients, and it is from this published guide that the methods employed by Henderson to case note-taking in the early 1920s may best be understood. Kirby, whose professional career was deeply entangled with Meyer's, was instrumental in personally demonstrating to Henderson Meyer's psychobiological approach to clinical study. In 1908 Henderson worked as a junior staff member under Kirby within the New York State Psychiatric Institute, and almost two decades later it was from Kirby's guidebook that Henderson took inspiration for his own published account of the examination and recording methods that should be applied to psychiatric patients. George Hughes Kirby, 'Notes of Clinics in Psychopathology' privately printed in 1908, reprinted in Eunice Winters (ed.), *The Collected Papers of Adolf Meyer, Vol. III. Medical Teaching* (Baltimore: The Johns Hopkins University Press, 1951).

[21] Gayle Davis, *The Cruel Madness of Love': Sex, Syphilis and Psychiatry in Scotland* (Amsterdam: Rodopi, 2008), 28.

[22] David Kennedy Henderson and Robert Dick Gillespie, *A Text-Book of Psychiatry for Patients and Practitioners* (Edinburgh: Humphrey Milford, Oxford University Press, 1927), 74; see also Meyer, 'Outlines of examinations', in Winters (ed.), *op. cit.* (note 20), 238.

[23] An occupational therapy ward (the first of its kind in Britain) was soon erected, alongside the establishment of a dental department, a surgical operating theatre, a new kitchen and dining hall. Certain ward units were also re-envisioned. Henderson promoted closer ties with general medicine through the employment of honorary consulting staff specialising in areas such as gynaecology, dermatology and ear, nose and throat, while strong reservations were shown towards more invasive, somatic modes of treatment such as hydro-electric and light therapy that were burgeoning in popularity amongst the British psychiatric profession. See Iain Smith and Allan Swan, 'Medical Officers and Therapeutics, 1814–1921,' in Jonathan Andrews and Iain Smith (eds), "*Let There Be Light Again*"*: A History of Gartnavel Royal Hospital from Its Beginnings to the Present Day* (Glasgow: Gartnavel Royal Hospital, 1993), 75.

[24] This expression was used by Henderson in a later book, but reflects his positive (if evolving) position on the subject of psychoanalysis. David Kennedy Henderson, *The Evolution of Psychiatry in Scotland* (Edinburgh: E. & S. Livingstone Ltd, 1964), 196; 216–17. For more on this topic, see note 85.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

syndromes, while interesting, are not of first importance'.[25] 'What is wanted,' he noted in the preface to his jointly authored *Text-Book of Psychiatry* (1927), 'is an understanding of the patient as a human being, and of the problems which he is meeting in a morbid way with his "symptoms"'.[26] Typical of Henderson's approach was his assertion that '[t]he physical and the psychological cannot be divorced – the individual must be treated as a whole'.[27] This philosophy, shared by Meyer and Henderson alike, guided Henderson to pursue psychiatry as a 'living subject' in relation 'not only to general medicine, but to the social problems of everyday life'.[28] 'It is in accordance with these principles', he wrote, 'and with what is called the "dynamic" view, that we have utilised clinical records so extensively'.[29]

The resulting records, based on the practices of North American colleagues, reveal materials in which the doctor–patient dialogues are preserved in an attempt to faithfully reproduce the patient's voice. These case notes capture, with remarkable clarity, some of the narratives, actions and anxieties exhibited by patients and psychiatrists as they interacted with one another. Contextualised against a backdrop of waiting rooms, patient dormitories, examination and consultation spaces, Gartnavel's dynamic case notes can be used by the historian to reconstruct a historical human geography of patient–psychiatrist interactions within these clinical confines. Yet, as we shall see, the question remains as to precisely how much construction and reconstruction is involved in the production – and later interpretation – of these records.

Setting the Stage: The Admission

During the summer of 1930, two male attendants accompanied a general practitioner to the house of a middle-aged male patient, Mr Patrick Johnstone.[30] Upon their arrival, the attendants remained outside Mr Johnstone's front room and, after 'much talk and argument' between doctor and patient, they were asked to enter. 'I looked round the room', an attendant later wrote, 'and noticed that lying near the door on the floor [were] a hatchet and splinters of glass'. 'Softly' laying a hand on Mr Johnstone's arm, he led the patient out of the room, but having reached the front door of the house Mr Johnstone 'made to run away'. While the attendant held him back, Johnstone began to 'shout for the police and '[mentioned] something about a warrant'. The doctor looked for a constable, but after it was made clear to Mr Johnstone that his wife would accompany him to Gartnavel, he was finally coerced into the awaiting motorcar. On the way to the hospital Mr Johnstone sat in silence. Upon reaching the entrance of Gartnavel, however, his demeanour quickly changed. Stepping out of the motorcar, he alighted the steps to the front door and, with a rapidity of pace, walked briskly into the male reception hall. He then stopped, pausing in order to light his pipe and, after having caught sight of one of the medical officers, Johnstone 'strode forward', 'cordially' offering his greetings to the medical officer, and stated his pleasure at meeting him.[31]

[25] Henderson and Gillespie, *op. cit.* (note 22), viii.
[26] *Ibid.*
[27] Quoted in Smith and Swann, *op. cit.* (note 23), 74.
[28] Henderson and Gillespie, *op. cit.* (note 22), viii.
[29] *Ibid.*, viii–ix.
[30] All names have been changed.
[31] The attendant's report was inserted within the corresponding case notes no. 777 GB 812 HB13/5/189/21, NHSGGCA. Quotes taken from case notes contain original spelling and punctuation.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

It is at this moment, when patient and practitioner met upon the threshold of the hospital, that the construction of a patient's case notes began. This was the point at which an individual became subsumed within the socially and diagnostically diverse – yet somewhat amorphous – mass of patients at Gartnavel (which reached an annual average of 450 predominantly middle-class residents).[32] Nursing attendants and general practitioners gave information as to the immediate actions of the person before admission. Then, gradually, as he or she entered the hospital, family and friends were invited to give information about the patient's history, so that case notes built up a picture of the individual from the joint perspectives of medical professionals and lay informants.

For Gartnavel's psychiatrists, the point at which their attention shifted from the narrative of lay informants and medical certificates towards first-hand clinical observation marked a distinct turning point in the medical record. At this juncture, the temporality of the case note changed to the immediate observation of the patient as he or she adapted to hospital routines. During admission, when forms were presented and/or letters signed (based on whether the individual was a 'certified' or 'voluntary' patient),[33] the waiting room signalled an individual's legal, temporal and physical transition to institutional care. It was from within such a liminal space that Gartnavel's practitioners were presented with their first opportunity to capture a 'live' and 'continued account' of the patient's story as he or she entered the hospital.[34] Meyer viewed this moment of transition as a valuable 'experimental phase' which provided one of the most decisive opportunities to observe first-hand the individual's adaptive strategies to the demands of a new environment.[35] In accordance with Meyer's investigational techniques, the process of admission thus allowed Gartnavel's medical officers to observe these adaptive strategies in a set of controllable, easily replicable environmental conditions. The journeys, waiting rooms and wards here became the backdrop to individual life histories. Each of those sites were considered part of what Meyer termed the 'pathological laboratory' to which the patient was observed to adapt, consigned in vignettes of the admission process which were thought to afford a 'natural picture of . . . psychobiological maladaptation'.[36]

While Henderson similarly envisaged Gartnavel as a 'pathological laboratory', he also saw it as a therapeutic space in which one could potentially cure patients' allegedly dysfunctional behaviours. It was crucial to Henderson's approach that a patient recognise his or her condition as a mental illness that necessitated treatment within a hospital by medical professionals. As such, conforming to the hospital regime and accepting the authority of the psychiatrist was considered one of the first steps to therapeutic success, requiring the patient to adapt to this new 'social reality'.[37]

Compliance and Resistance

Case notes highlight the diversity of patient experience during the admission procedure. One of the most important factors affecting an individual's reaction to this new setting, as observed by Henderson, was his or her status as a voluntary or certified patient. Early in his career he stressed that the 'line of division' between those patients predisposed to recovery

[32] *The Annual Report of the Glasgow Royal Mental Hospital* (Glasgow Royal Asylum) (Glasgow: Glasgow Royal Mental Hospital, 1914–30), GB 812 HB13/2/101-117, NHSGGCA.
[33] This distinction, which is characteristic of Scottish psychiatry at this period, is discussed below.
[34] Adolf Meyer, 'Outlines of examinations', in Winters (ed.), *op. cit.* (note 20), 237–8.
[35] *Ibid.*, 243.
[36] *Ibid.*, 236.
[37] Adolf Meyer, *op. cit.* (note 6), 162; Henderson and Gillespie, *op. cit.* (note 22), 69, 537–42.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

and those who failed was often drawn between the 'cooperative and non-cooperative' patients, not between 'any supposed standard of sanity or insanity'.[38] Throughout the 1920s Gartnavel's admission staff therefore diligently recorded whether patients showed fear and/or ambivalence upon admission, or, by way of contrast, demonstrated acceptance and eagerness to submit to the hospital's treatments. My analysis suggests that there was, indeed, a correspondence between level of compliance to the hospital regime and patients' admission status. Sources show numerous occasions on which certified patients were recorded as resisting, evading and distrusting the legitimacy and efficacy of hospital care, while voluntary patients more often took on the role of what would now be called 'service user' by cooperating with, or even negotiating, the terms of their treatment. This crucial (if under-studied) dimension of hospital care distinguishes Scottish patient stories from those of their English and especially Continental counterparts. Indeed, voluntary boarding was generally seen in the nineteenth century as a typically Scottish feature.[39] In England, on the other hand, voluntary admission to rate-aided mental hospitals was not widely practised until the 1930 Mental Health Act.[40] In Gartnavel's Annual report for the year 1923, 45 per cent of patients admitted that year were classified as voluntary. This rose to an average of 50 per cent in 1924, and 60 per cent in 1927. (Further research into the background of voluntary patients may show that such admissions may have been related to social class. Yet preliminary investigations suggest that voluntary patients ranged from the highest fee-paying boarders, paying £160 per annum for their treatment, to the lowest ones paying £1 10s per week.[41])

This contrast between voluntary and certified patients is illustrated in the case notes of Harriet Paterson, a young female patient who entered Gartnavel as a certified patient in 1924. After being transferred from a nursing home, she arrived dressed in what was described as a 'flimsy evening frock' and, through a cascade of tears, she protested against her 'forced' admittance. Under the close attention of a clinical clerk, it was reported that Paterson regarded her father as having 'no legal right' to 'force … her into an asylum'

[38] David Kennedy Henderson, 'Remarks on Cases Received in the Henry Phipps Psychiatric Clinic', *Bulletin of the Johns Hopkins Hospital*, 30 (March 1914), 277.

[39] Aude Fauvel, 'Psychiatrie et (des)obéissance: écrire à l'asile au XIXe siècle, l'expérience écossaise', in Falk Bretschneider, Julie Claustre and Isabelle Heullant-Donat (eds), *Règles et dérèglements en milieux clos, VIe-XIXe siècles* (Paris: Presses Universitaire de la Sorbonne, 2015). At Gartnavel, many patients were allowed to engage in artistic and literary activities, many of which were reproduced within the asylum's own *Gartnavel Gazette*, a magazine that was almost entirely produced and written by patients. This was not the case in other countries. Jonathan Andrews, 'The Patient Population,' in Andrews and Smith, *op. cit.* (note 23), 109; see also Hazel Morrison, 'Conversing with the psychiatrist: Patient Narratives within Glasgow's Royal Asylum, 1921–39, *Journal of Literature and Science*, 6, 1 (2013), 18–37.

[40] For exceptions, see Sarah Chaney, 'No "Sane" Person Would Have Any Idea: Patients' involvement in late nineteenth-century British asylum psychiatry' (this volume).

[41] This distinction between per annum and per week patient rates, found in the annual reports, might be significant: it might refer either to the length of the patients' treatment or to their socio-economic status, which would determine their ability to pay up front in full or merely on a weekly basis. However, more research would be needed to analyse these data on gender and social class. In any case, we know that Gartnavel was populated by a predominantly middle-class, private, fee-paying clientele. See David Kennedy Henderson, 'Report of the Physician-Superintendent for the Year 1923', in *The One Hundred and Tenth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) for the Year 1923* (Glasgow: Glasgow Mental Hospital, 1924), 13, 19; 'Report of the Physician-Superintendent for the Year 1924', in *The One Hundred and Eleventh Annual Report of the Glasgow Royal Asylum for the Year 1924* (Glasgow: Gartnavel Mental Hospital, 1925), 16; 'Report of the Physician-Superintendent for the Year 1927', in *The One Hundred and Fourteenth Annual Report of the Glasgow Royal Mental Hospital (Glasgow Royal Asylum) for the Year 1923* (Glasgow: Glasgow Mental Hospital, 1928), 17.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

because she was a married woman. Still crying and showing herself as 'very distressed' to the medical officers, she explained that it was not a 'legal marriage' but rather a 'physical marriage' – a 'Scotch marriage', and that 'there was nothing immoral about her'.[42] Annabel Brown, another young female patient, is similarly recorded as having sat in the reception room:

> clinging to her father, very pale faced and distressed, not demanding to be taken away, but making no move to go to the ward with sister, and expressing fear + doubt − imploring her father to give her just another minute, kissing + embracing him in a manner painful to observe. He, himself, showed much indecision of mind, encouraging her in her embraces, asking [Medical Officer] if he were sure this was the best place for her, enquiring how she would be treated etc.[43]

In the introduction to *A Social History of Madness*, Roy Porter called for in-depth investigation into the socio-historical contexts that inform the narratives of those considered mentally ill. Focusing on the ways in which patients 'negotiated definitions of their illnesses' as well as how they 'viewed themselves as patients and individuals', Porter explored illness as a mutable, indefinite concept, aligned to changing notions of individual and social identity.[44] The vividness of these descriptions in the Gartnavel records is valuable in that it throws light on the social processes behind dynamic case note construction. These sources enable readers to engage with the wider socio-historical contexts as well as the subjective and interpersonal relationships that gave meaning to an individual's actions. Harriet Patterson's case, for example, illustrates that conflicting inter-war notions of morality, authority and legality played a role in her attitude. Her behaviour suggests that her own perception of her admission was based upon (and shaped by) cultural norms rather than strictly medical notions of health and illness. Therefore, factors such as class and gender are integral to our understanding of this story. These patient narratives shed light on what it meant to be classified as mentally ill in a period in which common cultural understandings of mental illness were interwoven with notions of sexual (a)morality and transgressive gender roles. Case notes reflect these common cultural discourses, signs and symbols. They also show that patients (especially certified ones) developed complex strategies of resistance to counter the medical authority and preserve their sense of agency.

A different picture emerges when looking at patients admitted by their own will. Duncan Barrowman, a voluntary boarder transferred from Stirling District Mental Hospital, declared that he was glad to arrive at Gartnavel as he was 'fed up' with his former co-patients.[45] As for George Armstrong, also voluntarily admitted in late November 1925, he 'plunged straight into a long rambling discourse about his symptoms beginning with pimples on his anus + ending with a heat in his throat' − all while signing the voluntary forms in the male reception room. Haggling for his treatment, Armstrong stated that he was willing to pay anything up to £20 weekly, but the clinical clerk noted that he insisted that he should have things done 'exactly as he wanted them'.[46]

[42] Case notes no. 268 GB812 HB13/5/181/36 NHSGGCA.
[43] Case notes no. 790 GB812 HB13/5/189/34 NHSGGCA.
[44] Roy Porter, 'Introduction', *A Social History of Madness: The World Through the Eyes of the Insane* (New York: Weidenfeld & Nicolson, 1987).
[45] Case notes no. 302 GB812 HB13/5/182/12, NHSGGCA.
[46] This patient, after several weeks at Gartnavel, eventually discharged himself after finding his treatment unsatisfactory. Case notes no. 301 GB812 HB13/5/182/11, NHSGGCA.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Patient Stories: The Physical and Mental Examination

The physical examination played an important part in the hospital routine and, as such, featured prominently in case notes. Here, records similarly capture vignettes of patients' reactive strategies towards the rules, regulation and 'reality' of their new status. Typical of these examination records are statements attesting to the individual's general health, with observations made about pulse, cleanliness of tongue, physical build, distribution of hair, reflexes, and so on. It was in this part of the hospital routine, following admission, that patient 'stories' began to emerge more clearly in records, leading to the more in-depth 'mental examination'. However, as this section indicates, various factors determined the patients' willingness to tell their stories. In cases where the reactions of a patient to the physical examination provoked him or her to enter into conversation with the psychiatrist to discuss symptoms and experiences, these dialogues could find their way into the case note. Before discussing these processes of authorial selection by medical authorities, it is important to get a picture of the way in which an array of power structures, narrative conventions and spatial parameters shaped the dialogues that passed between patients and doctors.

Newly admitted patients underwent the physical examination in the ward, behind drawn curtains. Their experiences are recorded as ranging from compliance and passivity to fear, hostility and resistance:

> She was extremely unwilling to allow a physical examination to be done. She refused to allow the chest to be examined saying that she understood this to be a mental hospital and that she did not see what examination of a patient's chest had to do with mental disease . . . . The necessity of making a physical examination was explained to her but she still persisted in her unreasonable attitude . . . After a great deal of delay and persuasion she allowed the examination asking in a sarcastic tone as it proceeded if the MO [Medical Officer] could find any evidence of mental disease from his examination.[47]

Patient narratives, whether elicited upon admission during the physical and mental examination or later in the open ward, sometimes held aetiological significance. One morning in July 1929, a medical officer was conducting his rounds when, upon entering one of the female wards, he observed Miss Elizabeth Murray, a newly admitted voluntary patient, acting in what he characterised as a 'high' state. Upon Miss Murray's admission to the hospital the previous day it had been recorded that she spoke to herself 'a great deal' and at times 'got very impulsive'. During the latter part of the morning she had lain in bed: 'her eyes', observed a clinical clerk, 'were flashing and she immediately made strange signs.' The notes indicate that as the day went on '[s]he blew from her mouth and made movements of her arms which seemed to indicate that she was pushing or brushing away the medical officer.'[48] The next day Miss Murray remained in bed and reportedly became 'very antagonistic' when a doctor came to sit next to her. Speaking in a 'loud declamatory voice', she warned that if he remained seated in front of her she would spit on him. The medical officer noted: 'I sat. She spat on me, three times; and then she said something like "Thank God, Thank God, he does not flinch"'. As she calmed down, curtains were drawn around the bed and Miss Murray allowed the nursing sister to 'arrange her dress' for the physical examination. The medical officer then began to examine her, but 'again she showed momentary flashes of antagonism' and proceeded to 'sing aloud "Danny Boy,

[47] Case notes no. 330 GB 812 HB13/5/182/40, NHSGGCA.
[48] Case notes no. 690 GB812 HB13/5/187/90, NHSGGCA.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Danny Boy"' as the physician attempted to auscultate the thorax. 'Gradually', this period of excitement 'subside[d]' and he was 'finally' able to talk to the patient:

'Is your head clear?' 'Fairly'.

Do you feel confused? 'No' (definite)

Miss Murray then 'made reference to the coming of Heaven', and stated

how when she was a child she had a fancy. She looked into a looking glass and saw another room; and [said] that she had wished to get into that other room, the other side of the glass.

Miss Murray smiled when the medical officer mentioned *Alice through the Looking Glass*, but he remarked: 'she seemed to suggest . . . we were now "through the glass" – we were through the veil of Death into Heaven'.[49]

In cases such as this, the psychiatrist primarily studied the patient for signs of disease and physical disorder. However, he also used common cultural discourses, metaphor and metonymy to engage with the patient's inner world. While the clinical encounter was recorded from the perspective of the psychiatrist, the narrative 'from below' (including non-verbal forms of communication, such as a glance or spit) was accorded a high degree of significance and made its way into the case notes. To be sure, the organic origins of mental disorders were given etiological importance, as suggested by the above psychiatrist's attempt to 'auscultate the thorax'; yet records show that it was also crucial to let the patient tell her story. By forging a linguistic bridge between the reality of the patient's own world and the world jointly shared by patient and psychiatrist, Henderson sought to promote an empathic, non-reductionist approach. For him, descriptive statements such as 'He is delusional' were not sufficient. Rather, it was considered of great value 'to get an exact description of the delusions and hallucinations [if any were present], and how the patient has reacted to them'.[50] 'It is not the situation itself that matters', he noted, 'but what the subject feels about it', that was of greatest significance.[51] Yet precisely what psychiatrists did with the patient's story is made most evident in the ensuing mental examination.

Mental examinations often followed a systematic line of enquiry. As mentioned above, by the early 1920s dynamic case-taking guides were being published in North America, and an analysis of Gartnavel's case notes reveals a resemblance to these published procedures.[52] These guides advised that medical officers begin the examination by assessing the patient's 'stream of mental activity' and studying their 'emotional reaction (affect)', their 'mental trend: content of thought' as well as their 'insight and judgement'.[53] Patients' inner worlds, feelings and mode of communication were to be judged in relation to their appreciation of the shared 'reality' of the world around them. As several cases suggest, both patient and psychiatrist could fight to establish the reality of that shared world. Indeed, as with the physical examination, the flow of the conversation could be resisted or disrupted by the patient's actions.

Thus Robert Norton, admitted in 1926 as a voluntary boarder, 'rather resented being asked questions'. Reflecting on the encounter, the examining psychiatrist wrote:

[49] *Ibid*.
[50] *Ibid.*, 72.
[51] *Ibid.*, 59.
[52] Eg. see Kirby, *op. cit.* (note 20).
[53] Henderson and Gillespie, *op. cit.* (note 25), 74–80.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

He . . . discussed the way in which the questions were put, was suspicious of my motives in questioning him, and he refused to allow me to take any notes. He said that if I took notes he would refuse to speak to me at all . . . He constantly repeated the questions I asked him, he found fault with it in various ways, he complained about the manner in which it was asked, he took exception to the way I sat on a chair besides his bed, and eventually he refused to co-operate any further, finishing up by saying that he considered I was just as insane as he was.[54]

In this case, the patient interpreted the act of note-taking as intrusive. Others felt that it heightened their lack of privacy. The record of Harriet Smith indicates that she:

showed a natural anxiety that what she said was not overheard by anyone else in the ward. At one point in the examination she asked anxiously if anyone saw the report and said she did not like notes being taken of what she said.[55]

The spaces in which these initial examinations were conducted are important to understanding this resistance 'from below'. Case notes reveal that patients often remained within their dormitory beds, surrounded by other patients and ward nurses. The open dormitories that housed many of Gartnavel's lower-class patients necessitated curtains be drawn around the interviewer and interviewee. Indeed, there is evidence to suggest that mental examinations, conducted in such a public place behind only the flimsiest of partitions, could prove an inconducive environment for the revelation of patient stories.[56] Without the establishment of trust, Henderson and his colleagues were denied access to the patient's story and therefore deprived of the dialogue that was so central to their investigative methods. Case notes highlight the fact that obtaining the illness narrative was often a thing to be hard won, not given over lightly or indeed entirely by the patient. This, interestingly, was true for both voluntary boarders and certified patients.

It was not atypical, then, for medical officers to have to fight to establish such a dialogue. On a morning in May 1921, a certain Miss Margaret Beaton lay crying in bed as Henderson and an accompanying clinical clerk entered the ward and sat beside her. A preliminary discussion between Henderson and Miss Beaton ensued, followed by the formal mental examination. Having been informed by a ward nurse that the patient had not slept since her arrival, Henderson found her to be in a highly emotional state. Frequently sobbing throughout the interview, her general sullen appearance was noted by the clinical clerk, while Henderson began an analysis of his patient by systematically exploring the 'different mental fields' (grouped under 'behaviour', 'personality', 'intellect', 'affect' and 'insight').[57] Henderson opened the conversation with a succession of simple questions, asking Miss Beaton to confirm her name and her general complaints, with the purpose of eliciting spontaneous speech.[58] He obtained a perfectly lucid response from her and no evidence of organic disturbance was noted in the interview transcript. Henderson therefore proceeded to enquire about the degree of insight Miss Beaton had into her condition.[59] Endeavouring to ascertain whether she considered herself mentally ill and

[54] Case notes no. 398 GB 812 HB13/5/183/54, NHSGGCA.
[55] Case notes no. 426 GB 812 HB13/5/184/23, NHSGGCA.
[56] New Case Book Series: Females Vol. 28, HB13/5/176, NHSGGCA.
[57] Kirby, *op. cit.* (note 20), chapter 4.
[58] Periods of mutism, distractibility or the erratic and disconnected flight of ideas could often characterise a patient's narrative, and such linguistic disturbances were taken to signify underlying functional disorders. See Henderson and Gillespie, *op. cit.* (note 25), 74–5.
[59] Henderson and Gillespie's *Text-Book of Psychiatry* stipulated that in the mental examination the interviewing psychiatrist should question 'the amount of realisation the patient has of his own condition; does he realise that he is ill, that he is mentally ill, that he is in need of treatment in a mental hospital?' *Ibid.*, 80–1.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

whether she would co-operate or resist the examination process, he asked: 'Why are you here?' Miss Beaton replied:

'I was foolish, selfish and stubborn and rather a bad temper and this is what they've done'.

'Who? your mother and brother'?

'Yes. Do you think I'm like these people round about' (the patients).

'Depressed?'

Her home, she replied, was depressing, characterised by 'poverty and unhappiness'. Her mother was described as a woman who would 'never give into anything', 'was suspicious of everyone' and whose old-fashioned ways clashed with her own. Henderson suggested that her mother's suspicions may have been justified, as he reminded Miss Beaton that she had herself threatened her mother in various ways. 'I didn't mean it', she responded.

As Henderson drew the conversation towards the domestic sphere, Miss Beaton's present actions and emotions began to take meaning in the context of his psychotherapeutic model. He sought out a longitudinal history that would show whether her emotional outbursts and depressive states periodically reoccurred throughout her life history, or whether such incidents were more dependent upon present environmental factors (and might therefore be more amenable to treatment). After he had asked Miss Beaton whether she could explain her general irritability, she replied:

'I haven't had anything that other girls have had'.

'Life's hard?' suggested Henderson.

'Yes'

'Sick of the thing?'

'Not all together'. [sic]

When asked about her friends, Miss Beaton replied that she was always 'one too many', that no one took her side and that everything was always blamed on her. As Henderson reflected upon Miss Beaton's self-reported history of fraught familial relationships and social isolation, he began to analyse the depression and anger she exhibited within the mental examination from a longitudinal perspective. Since she projected the source of her troubles on to others, Henderson tried to reassure her that her family wanted to make her better. The patient replied:

'I don't think so. Do many a thing for punishment'

'We want to help you'

'I don't think it's the way to make me – not people, the type of people'.

'Dr Henderson said it worked out although not apparently likely on surface'.

'That isn't so' . . . This has ruined me. They'll triumph over me; they 'don't care a bit'

This idea was disagreed by Dr Henderson; but she persisted it was so.

Here, we see the patient's narrative conflicting with Henderson's, both aiming to establish the 'reality' of her situation. Miss Beaton insisted that her confinement to Gartnavel was a form of punishment; that her family had sullied her reputation and cast her from her home. The intensity of her emotions, depth of despair and strength of her antagonism flowed out in one long tirade. Also highlighted in this case is the multi-vocal nature behind the production of such records. At one point, Miss Beaton momentarily turned her attention away from Henderson to confront the attendant clinical clerk. 'I know you're taking notes', she stated, thus breaking away from the enclosure of a two-way dialogue. All at once we are reminded that this interview was not carried out within an

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

enclosed and private space, but in an open ward, among medical staff of whose gaze she was fully aware. Behind the overt content of the mental examination report, we are subtly alerted to her surroundings, to the recording mechanisms that actively shaped her dialogue and to an indistinct, yet pervasive, sense of the clinical atmosphere still infusing the transcript. These examples point to the complex physical and social conditions behind note production, which directly or indirectly made their way into patient narratives.

On a formal level, this excerpt also illustrates the authorial process behind case note production. The various grammatical choices and narrative stylistics (for example, quotation marks within quotation marks), while revealing something of the tempo and rhythm of speech, are not reproduced uniformly throughout case note records; indeed they are also prone to inconsistencies in punctuation. My approach here is to replicate, as far as possible, the original layout, as well as any grammatical errors or inconsistencies that appear within the original sources. By retaining such inconsistencies, I retain layers of authorial agency to highlight that case notes cannot, alone, be used to understand the subtleties of these narratives 'from below'.

In this respect, it also becomes important to draw a distinction between records produced at the time of a clinical encounter and those retrospectively compiled in an administrative environment. This is significant when considering the kinds of information recorded by the first-person observer and that which may have been revised and altered in the hours, days and months after clinical observations. For instance, upon the arrival of a new patient at Gartnavel the task of the clinical clerk was to transpose admission data (such as medical certificates) into the case note record. The information was often typewritten and produced in an administrative, rather than a specialist clinical environment. Other records of mental and physical examinations, however, were often penned by hand in the ward, in close proximity to the patient. Meyer wrote, unequivocally, that notes should be written down at the time of observation; for him, this offered a more immediate, unrevised investigation of events as they unfolded. However, mental and physical examination records show revisions and overlays of additional handwritten, sometimes typed, observations. Different handwriting styles and typewritten sections attest to the thought development of one or more medical officers, showing the process of case note construction to be a fluid, sometimes unstable and often collaborative process.

The 'staff meeting' was, for a number of patients, the next stage in their analysis, as Gartnavel's medical officers endeavoured to construct clinically rigorous 'dynamic' case notes which would follow Meyer's model. As Henderson remarked, '[i]n order to get at the dynamic factors . . . it is usually necessary to have repeated interviews and finally to make a careful analysis of the entire material'.[60] Staff meeting records, which were reproduced in verbatim transcriptions, bear marks of the introduction of new recording technologies and further stylistic forms of narrative representation. The following section illustrates how the disparate parts of the physical and mental examination were drawn together in the staff meeting, highlighting the marriage of voices 'from below' and 'from above' in case note construction.

Patient Stories: The Staff Meeting

Staff meetings, which pre-dated the contemporary 'case conferences', were put into use at Gartnavel from 1921 onwards.[61] Following Meyer's practices in the United States,

[60] Kirby, *op. cit.* (note 20), 68.
[61] Smith and Swann, *op. cit.* (note 23), 329.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Henderson instigated the routine by which Gartnavel's staff gathered within a meeting room three mornings a week and were introduced to newly admitted patients to discuss their cases. Used as an educational and training exercise, the staff meeting consisted of a single examining psychiatrist directing questions towards the patient, while a trained stenographer, who sat silently among the staff, recorded in verbatim fashion the conversation that passed between patient and practitioner.

In accordance with Meyer's so-called psychobiological principles, the staff meeting was considered yet another 'experimental stage' upon which patients' reactive tendencies were to be judged and given meaning. So, while the acts and utterances of patients were recorded, so too were the provoking actions of the psychiatrist. Transcribed from the perspective of the stenographer who sat clicking away at their stenographic machine, these materials reveal, most clearly, the interactive dimensions of those clinical encounters. By preserving the raw dialogues that passed between the various actors, such sources allow an in-depth hermeneutic enquiry into the illness narrative as it was shared, modified and negotiated by both medical officer and patient. These transcripts are, in many ways, a more direct source of patient narratives than the case note record. For instance, they contain a more uniform application of grammar, with the dialogues of patients and medical officers recorded in straightforward question-and-answer format. They are also the product of single typists – rather than a conglomerate of writers – who recorded, word-for-word, the events of the staff meeting at the time it was conducted. Finally, these materials reveal the presence of other members who also, directly or not, contributed to shaping these dialogues.

Several days, sometimes weeks, after arriving at the hospital, many of Gartnavel's newly admitted patients were encouraged to attend the staff meeting. Escorted by a nurse from their respective wards to the ground floor meeting room, the patient was greeted by a medical practitioner upon arrival. Asked to sit down, he or she was directed to face the interviewing medical officer, while a gathering of Gartnavel's resident staff were seated behind the patient. 'I usually try to see every person who comes here in this way', Henderson stated to one patient during a staff meeting in 1925, to 'have a talk over things with them.'[62]

As within all mental examinations carried out in Gartnavel during this period, the perceived efficacy of this approach depended a great deal upon the patient's willingness to co-operate. However, for a number of individuals, the social setting of this event was itself a significant factor in shaking their confidence. Speaking in the presence of several members of staff created a further loss of intimacy. A certain Miss Mary Smith, for example, was 'very agitated, and very averse to coming into the room'. Asked by Henderson 'What makes you so frightened?', Miss Smith failed to respond and became 'very anxious that the nurse who accompanied her, and Dr Henderson and Dr Thomson, should be seated, while she herself insisted on standing throughout the interview'.[63] Another staff meeting transcript highlights how the presence of multiple staff members could alter the tone and content of a patient's narrative. Complaining about her hospital conditions, Mrs Mary Cranford exclaimed: 'I am just kept like any common prisoner. I am very angry. (*laughing*) Wait till I get out!' The board of medical officers, who were sitting behind her, had gone unnoticed until this point; she then turned around in her chair and

[62] Case notes no. 631 GB812 HB12/5/187/31, NHSGGCA.
[63] Case notes no. 439 GB812 HB13/5/184/36, NHSGGCA.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

said: 'Excuse me, gentlemen, I did not know you were sitting there or I would have been a little bit more cautious.'[64]

Patients did not easily confide during these encounters. In order to establish confidence and encourage the patient to speak, Henderson and Meyer both advised that he or she 'be treated absolutely on an equal footing with the physician'. If an adequate level of trust was established between the two parties, one of the first steps taken to understand the patient's supposedly dysfunctional behaviour was to develop a 'sensitivity to the 'stories, [which] the patient may just by chance tell'.[65] Delusional statements, wrote Meyer, 'must be accepted as one would accept the religious convictions of a person of a different denomination', while remarks made to other psychiatrists 'must show the same consideration; no pressure must be used'.[66] Moreover, 'in order not to disturb [the patient's] sense of safety or make [her] suspicious that confidences are being betrayed', the physician should 'as far as possible' only engage in topics of conversation that have been 'worked out and discussed conjointly with the patient'.[67] Rather than the medical officer's narrative running counter to the alleged delusional beliefs or 'rigidly conceived premises' held by the patient, the practitioner engaged – and indeed endorsed – the inner reality of the patient's own experiences. Meyer advised that, through a process of compromise, ideas pertaining to this shared 'common reality' gradually be introduced into the conversation. By encouraging their interlocutors to elucidate further the meaning of concepts and phrases particularly pertinent to the case within the staff meeting, medical officers endeavoured to comprehend a patient's own, sometimes unique, usage of language:

'*Patient*. "I can always do much as I like – but I don't function properly. You have heard of such cases before, but it is a freakish state; you have heard of men who can do unnatural things with their bodies . . . You have heard about the Clincher? Haven't you? That man has his mental balance – he seems to work from his head. You know what I mean?

Dr Henderson. How do you mean work from his head?

Patient. "Well, he does not work as any other natural man would" . . .

Dr Henderson. You have spoken about your spine shifting. Do you believe that your spine is –

Patient. (*breaking in*) Yes I do. When the change comes on it about knocked me off my mind altogether. I think it was me getting the wind up. – it made my nerves worse. A man who is in proper condition has a proper spine – mine is twisted. It is with me getting the wind up this fortnight."

Dr Henderson. What change has come over you by getting the wind up?

Patient. 'It has turned the wrong way'.[68]

Contextualising and further clarifying the meaning of phrases such as working 'from his head', having one's 'spine twist' or to get the 'wind up' enabled Gartnavel's practitioners to establish a shared, common language through which to establish confidence and understanding.[69] This was considered an initial step in the process of correcting a patient's 'faulty' adaptations. In this respect, it is interesting to note that while patients were encouraged to act as 'collaborator[s] in the treatment endeavour',[70] these stories could undergo revision as the meeting progressed.

[64] Case notes no. 617 GB812 HB13/5/187/17, NHSGGCA.
[65] Meyer, *op. cit.* (note 6) 157–60.
[66] Meyer, *op. cit.* (note 35), 240.
[67] Meyer, *op. cit.* (note 18), 157. Henderson and Gillespie, *op. cit.* (note 25), 68; Meyer, *op. cit.* (note 6), 112.
[68] Case notes no. 142 GB812 HB13/5/179/42, NHSGGCA.
[69] Meyer, *op. cit.* (note 18), 160–1.
[70] Stanley W. Jackson, 'A history of melancholia and depression', in Wallace and Gach (eds), *op. cit.* (note 9), 455.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

At the beginning of her interview, for example, a patient named Helen Davidson was determined to reveal nothing on the subject of spirituality. After having earlier intimated her belief that she was the Virgin Mary, she was interviewed by the medical practitioner:

'Q. Was there any intimation conveyed to you from any outside source in regard to this? How did it come to you?

A. "I cannot very well explain".

Q. Did you have a feeling as if there was some Heavenly Presence intimating this thing to you?

A. "No".

Q. As if there was a Heavenly Voice that said this thing to you? Did it seem to come from your own inner consciousness, or what? Was it something that seemed to grow up inside you?

A. "No".

Q. How was the information conveyed to you then?

A. "By reading".

Q. By reading what?

A. "I cannot very well explain to you".

Q. Was it by reading the Bible, by reading about the Virgin Mary?

A. "No".

Q. Reading about Lourdes, or something else?

A. "No".

Q. What was it that specially seemed to convey that idea to you?

A. "The Bible".'[71]

As tensions between this patient's narrative and that of the psychiatrists saw the patient contradict herself, denying, then confessing that these ideas sprang from reading the Bible, the reader is made aware of the active re-negotiation of a patient's life history within this setting. We are reminded that we cannot unearth an essential 'truth' about a patient's history; instead what appears is an active co-construction of the patient's narrative. The reader is confronted not with the meeting of two dichotomous narratives, but with an array of stories, being continually reshaped and revised in (and beyond) the meeting. Amidst these processes of co-construction and reconstruction, new meanings and new identities emerge.[72]

How to interpret and compare the authorial presence behind the semi-verbatim transcriptions of the physical and mental examinations with the verbatim transcriptions of the staff meeting? The role of the stenographer here takes on special importance. Though barely considered by Meyer[73] and not at all by Henderson, the presence of this significant player in the staff meeting (which by then was becoming widely practised in North America due to Meyer's influence and teaching) was given some consideration in a 1937 article published in the *American Journal of Psychiatry*:

[71] Case notes no. 330 GB 812 HB13/5/182/40, NHSGGCA.

[72] Staff meeting transcripts include further developments in the consultation process after patients' departure from the meeting room. As such, an analysis of these sources would shed additional light as to the practices of debate, discussion and deliberation that preceded diagnoses and the formation of future treatment plans. For an in-depth investigation of these materials, see Morrison, *op cit.* (note 5) Chapter 5.

[73] Meyer, in Winters (ed.), *op. cit.* (note 15), 86. Meyer merely mentions the necessity of employing a stenographer in the wards and within staff meetings.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Presumably for the sake of the records a stenographer is present. It is a pity she cannot be made invisible.[74] Upon the other hand, a clever one can be trained to make running comments and notes upon the patient's responses when these concern solely matters of fact, thus avoiding in part the long series of questions and answers which present such a hopeless array upon many staff conference records. A signal system can be readily devised for informing the stenographer when to make verbatim records, when to summarize and when to make no notes whatever.[75]

This wish for invisibility of the stenographer is, in many ways, a reflection of the stenographer's discretion on the pages of Gartnavel's staff meeting transcripts. Unlike case note records, which intersperse verbatim samples of speech with clinical observation, Gartnavel's stenographers leave only the barest of clues upon the transcript as to their authorial presence. Only occasionally do the stenographer's own observations break through into the transcript, to offer summaries of staff members' comments or give brief indications as to the actions and behaviours of patients. It is from these brief asides that we glean a sense of the pace and tone of the conversation, of the groups and individuals to which certain statements were directed, and of the movement and unspoken interactions within these enclosed meeting rooms. The third-person narrative of the stenographer contrasts sharply with the first-person authorial tone of the medical officer. Indeed, verbatim samples of speech are clearly distinguished from the stenographer's own summaries. When examining the stenographer's use of punctuation and descriptive inserts, we notice, in many cases, that the pace and tempo of the patient's voice is preserved in the way of stage directions (for example, 'very slowly and deliberately'[76]). Indications are also given to mark those points where dialogue jars, with voices cutting across or over-spilling into one another. As for exclamation marks, although used sparingly, most appear within text that records Henderson's speech; and, although we cannot be sure of the exact tone or pitch of his voice, it appears to have been raised on a number of occasions:

Patient. 'I will investigate that you will be punished for keeping me staying here'.

Dr H. I am perfectly innocent – I have nothing to do with your coming here, you must not punish me![77]

Despite the above, records show that patient narratives in the staff meeting were not always transcribed in fully verbatim fashion. When confronted with the colloquial use of words, stenographers tried to retain the characteristic phrases and mannerisms that marked patients' language; but on occasion a certain accent or dialect could present too difficult to replicate. The stenographer then imposed a more formal arrangement within the transcript '(This patient spoke with a marked brogue, and in a low voice at times, and it was difficult – indeed impossible – frequently to catch what he said)'.[78] These notes, which endeavour to represent textually the structure, fluidity, tempo and intonations of spoken dialogue, not only highlight the interpersonal relations shaping one another's responses. They also emphasise the subjectivity of their authors. By casting light on the mediatory role of the stenographer, such passages interrogate the nature of (purportedly transparent) verbatim records in the making of patient stories 'from below'.

[74] We notice here the gendering of roles in North American mental hospitals, with this article assuming that the majority of stenographers were women. This was presumably the same in the Scottish context.
[75] Charles F. Read, 'Clinical Staff Conference', 1395. Clarence G. Schulz, writing in 1978, also reveals that Harry Stack Sullivan, a former student of Meyer's, used a stenographer within staff conferences in the years 1926 and 1927. Clarence G. Schultz, 'Sullivan's Clinical Contribution During the Sheppard Pratt Era – 1923–30', *Psychiatry*, 41 (2) (1978), 117.
[76] Case notes no. 310 GB812 HB13/5/182/20, NHSGGCA.
[77] *Ibid*.
[78] Case notes no. 301 GB812 HB13/5/182/11, NHSGGCA.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

Concluding Remarks

'Words are both crucially *reflective* of the goings-on in the human world, but also unavoidably *generative* of that world', write Chris Philo and Cheryl McGeachan.[79] As such, one must explore how psychiatrists, clinical clerks and stenographers not only recorded but also actively shaped – reconstructed – the discursive happenings of the clinical encounters at Gartnavel Mental Hospital. While these records allow glimpses into the patients' subjective worlds, they also reveal a process by which patient narratives were collected, compared and classified; that is, they highlight the epistemic virtue of such records in this rapidly changing context. As Michel Foucault theorised, the arrival of the case note facilitated the process by which patients were 'described, judged, measured, compared with others' so they may be precisely understood through their 'very individuality', and yet 'simultaneously corrected, classified, normalized or excluded' so that their identities became fixed by the 'medical gaze'.[80]

With these case notes revealing the profoundly polyphonic nature of mental examinations at that time and place, we may, therefore, question precisely how such sources – while rich in patient–psychiatrist dialogues – capture 'words' that exposed, and were generative of, the world around them. Unlike contemporary psychoanalytic case notes[81] which were effectively used to verify specific theoretical models, 'dynamic' case notes, as used by Henderson and Meyer, were intended to record the patient's verbally expressed 'wishes, desires and emotions' as standing 'above or in implicit precedence to any particular interpretation'.[82] These materials, while infused with the authorial agency of their psychiatrists, unveil a history of patient–psychiatrist dialogues in which the power to define the 'story of illness' ebbs and flows between both parties.[83] They show that physical as well as the interpersonal spaces in which the two parties spoke significantly shaped the content and delivery of their dialogues. Moreover, while psychiatrists endeavoured to penetrate the more intimate, interior spaces of the patient's mind – memory, thought, emotion and imagination – entry into these spaces had, largely, to be earned. It had to be given freely by patients themselves, whose stories were in many ways considered the key to unlocking the origins, meanings and possible treatments of their conditions. Patients' willingness to reveal their stories depended on a number of factors such as gender, social class and admission status.

Undoubtedly, dynamic case notes offer a rare window into the patient's view at that seminal period. Wishing to distance himself from psychoanalytic case studies, which placed patients' language within a rigid and specialised framework of understanding and

[79] Chris Philo and Cheryl McGeachan, 'Words', in Roger Lee and Noel Castree *et al.* (eds), *The Sage Handbook of Human Geography* (London: Sage, 2014), 3 emphasis in original.

[80] Michel Foucault, *Discipline and Punish, The Birth of the Prison*, Alan Sheridan (trans.) (New York: Random House, 1979), 191.

[81] This story is contemporaneous with the arrival of psychoanalysis in the British context. Philip Kuhn, 'Subterranean Histories: The Dissemination of Freud's Works into the British Discourse on Psychological Medicine: 19–1911', *Psychoanalysis and History*, 16, 2 (2014*b*), 153–214. For an intellectual and historical review of psychoanalysis in Scotland, which began to be more widely disseminated in the 1930s, see Gavin Miller, 'Scottish Psychoanalysis: A Rational Religion', *Journal of the History of the Behavioral Sciences*, 44, 1 (2008), 38–58. In his biography of R. D. Laing, Miller also provides an account of post-war psychoanalysis in Scotland. See Miller, 'Scottish psychoanalysis' in *R. D. Laing* (Edinburgh: Edinburgh University Press, 2004), chapter 5.

[82] Leys, *op. cit.* (note 13), 6.

[83] Katherine Montgomery Hunter, *Doctors' Stories, the Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991), 13.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press

interpretation, Henderson went to considerable lengths to reproduce a faithful, coherent account of complex clinical events.[84] But how far do these textual sources represent the reality they pertain to capture?

Due to new techniques of transcription introduced at that period, the historian can get a fuller picture of the complex social interactions between all members of the medical encounter and, in the process, analyse the important role played by patients in shaping this history 'from below'. Yet the conditions of production must also be taken into account when interpreting such materials. As Jonathan Andrews has shown in his study of Gartnavel's case notes in the nineteenth century, the influence of prevailing conceptualisations of mental illness has played a significant role in the changing degree to which physicians included the patient's voice in these records. Some of the greatest challenges for the historian reside in 'the areas of incompleteness and inter-textual discrepancies'.[85] In the same vein, if we know little about the process of case note selection in the 1920s, we also tend to overlook the process of interpretation by contemporaneous psychiatrists and historians alike, adding yet more levels of (re)construction.[86] As such, when considering the incorporation of sources 'from below', historians ought to keep in mind the context in which these stories were generated. This becomes all the more relevant in a setting in which verbatim and semi-verbatim transcripts are presented as narrative 'truth'. As I have shown, the analysis of institutional spaces, clinical practices and psychiatric forms of knowledge must also be taken into account when following Porter's call to explore the 'sufferers' role in the history of healing'.[87]

[84] It should be mentioned that Henderson did not altogether reject Freud's ideas; far from it. He and his colleagues selectively appropriated psychoanalytic theories to form their own eclectic blend of psychotherapeutics. This underwent revision over the years, as seen in staff meeting transcripts which show instances of debates and disagreements amongst the hospital's medical officers. In any case, Gartnavel patients at that period were not unaware of nascent psychoanalytic ideas, as illustrated in one of the case dialogues from 1924: '*Doctor*. How did he make your mind bleed? Was he attempting to treat you for a mental condition? *Patient*: He called himself a psychoanalyst! He may have read a little but I know far more about psychoanalysis than he does . . . He seemed to do nothing but flirt with me, so I left him.' (Case notes no. 268 GB812 HB13/5/181/36, NHSGGCA).

[85] Andrews, *op. cit.* (note 4), 262.

[86] For critical perspectives, see also Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5, 2 (1992), 183–205.

[87] Porter, *op. cit.* (note 1) 175–76.

https://doi.org/10.1017/mdh.2015.69 Published online by Cambridge University Press