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President 1962-3

[*Frontispiece*

https://doi.org/10.1192/bjp.109.459.168 Published online by Cambridge University Press

Brit. J. Psychiat. (1963), **109**, 169-177

Travels in Psychiatry

*The Presidential Address at the One Hundred and Twenty-Second Annual Meeting of the Royal Medico-Psychological Association held in London, 4th July, 1962**

By ISABEL G. H. WILSON

Doctors have climbed mountains with explorers and travelled the world with kings and statesmen; they have gone on humble journeys with sick folk, voyaged for money, fled from their enemies, sought new knowledge. We have travelled to learn about psychiatric opinion and practice abroad, and have greatly profited thereby.

The Association's library holds early records of what was going on in countries other than our own. The first number of our *Journal* in 1853 carried a report of a paper on "Monomania in a Psychological and Legal Point of View" by Dr. Delasiauve of the Bicêtre Hospital, Paris, and a note on "Opinion in Germany respecting Non-Restraint" (1). By 1858 it is obvious that the places described had been visited by the writers: an asylum in Venice, the Insane Colony of Gheel as well as other asylums in Belgium, and the institutions for the insane in Turkey. Careful notes and reviews of foreign literature began to appear, and continued year after year.

In 1905 Dr. Helen Boyle founded the Lady Chichester Hospital, and before that she had travelled in France, Austria and Germany. She had "got most inspiration" for the new venture from the clinic of the late Professor Cramer of Göttingen, as she told us in her Presidential address in 1939 (2). She was our first woman President and a courageous and cheerful friend to very many of us.

Thoughts about organized study tours for our own Association began to crystallize in 1927. The driving force was that phenomenally active man, Colonel J. R. Lord, who had announced that he did not mean to let the grass grow under his feet during the short term of his Presidency; nor did he. Among other things he reorganized the Research and Clinical Committee so that it had no fewer than ten sub-committees. The last on the list was for "Study Tours and Post Graduate Education" (3); it remained under the "Research and Clinical" till 1951, when it was put under the Papers and Discussions Committee.

The first study tour Secretary was Dr. A. E. Evans, who held the post until 1947. After that a number of us did the work or shared it at various times: Dr. Mayer-Gross, Dr. Ström-Olsen, Dr. Shapiro and myself. Since 1955 the sub-committee has been under the friendly hand of Dr. E. S. Stern.

Dr. Evans did a vast amount of work during his twenty years as Secretary. He arranged study tours, led them and reported on them, advised about post-graduate courses in America and on the Continent, wrote out plans, made introductions for individual doctors, and dealt with information about courses for the Diploma in Psychological Medicine. Meanwhile he was an Inspector and then a Commissioner of the Board of Control and finally one of the Lord Chancellor's Visitors. Everyone appreciated his kindness and his wide knowledge, to which, for example, tribute was paid in the report of the Dutch Study Tour in England in 1929 (19). He had charm of expression and manner but

* As delivered, this Address was based on a number of slides shown on the screen, of which it has only been possible to reproduce a few. Each country visited was represented by one or more pictures, and each picture also stood for one or other of the topics we studied. A few of the slides were from a series of drawings of my own on the theme of "The Famous Insane". I was glad to include these as a small offering of original work in an address drawn almost entirely from the work of others and from the pages of our *Journal*.

he was also determined and independent, qualities which have more than once saved a study tour from disaster.

There exists an R.M.P.A. postcard summoning a meeting, and written across it the pathetic words "N.B. No one attended but me. R. Ström-Olsen, Joint Secretary". We know how much *he* did in taking us to Scandinavia and bringing our Scandinavian colleagues here. The Scandinavians have been here twice; the Dutch have been twice; Belgian colleagues have been here once. A visit by Swiss psychiatrists had to be cancelled for lack of numbers, but we had a Swiss colleague with us on one of our tours in this country. There have of course been innumerable visits under other auspices, but here we can only consider those in which the R.M.P.A. was directly concerned.

We ourselves have travelled in twelve countries, including three in the United Kingdom. There has been no organized tour to America; one was planned for 1939 but was cancelled six weeks before the outbreak of war. The previous year Dr. Child and Dr. Watterson had visited Scandinavia with the help of the R.M.P.A. Research Bureau. Dr. Watterson wrote then (4) ". . . the Norwegians are more fortunate than we are; there are no crises looming over their horizon. Time is more or less endless and there is no bustle or scurry". How little did we know what was in store! It was only afterwards that we learned what other countries had suffered while we were unable to visit abroad: invasion, famine and death, and in some the shocking corruption of the morale of the young.

We have not toured in Austria, Canada, Finland, Ireland, Italy, Spain or the U.S.S.R., to mention but a few. We are apt to go more than once to the same places. A large visiting party can put a heavy burden on a small country, a fact which our generous hosts abroad keep hidden from us. It was one of our own countrymen who felt sib enough to us to greet us by asking "I am not sure whether you are a swarm of locusts or a flock of angels?" If we are angels, we are certainly devouring angels as we make our way through the land.

Records of our tours are exceedingly varied. One record (of a tour in Switzerland in 1938) consists of an album of photographs in our library. Some are brief lists of places visited but others contain long and detailed descriptions of buildings and beds, laws and lavatories, classifications and treatments, staffing, food, farms, furnishings, costs and crafts—a mass of information no longer relevant to our needs. I cannot speak at length of individual tours. I may not dally over the delights by the way; the sight of glittering icy mountains, lovely lakes and superb paintings; the taste of strange and delicious foods and drinks; the sound of enthralling talk and sweet music. Nor can I dwell on our despairs, when we were late, or lost, or inadvertently discourteous to kind people.

How good it was to be able to discuss what we had seen among ourselves at leisure and in pleasant surroundings in Amsterdam, or wherever we might be. Even better is informal talk with our colleagues of whichever country we might be visiting (Figure 1).

Occupation Therapy

"My road calls me, lures me
West, East, South and North.
Most roads lead men homewards
My road leads me forth."

So wrote John Masefield (5), and forth we went on our first Study Tour in 1928. It was the wish of Dr. Evans to show us occupation therapy according to the method of Dr. Simon of Gütersloh, in Germany, whose hospital had been visited by thousands of interested workers. In fact we did not visit Germany until 1932 (6); we saw Dr. Simon's therapy first in Holland. This "active" occupation therapy seemed at the time entirely original; for instance in the garden of one hospital we saw a young "inaccessible" schizophrenic wheeling a barrow, and whenever he set it down in mid-course, two male nurses, one on each side of him, curled his fingers gently round the handles and urged him forward again. I have since learnt that Dr. Paul Slade Knight introduced this same wheelbarrow technique at Lancaster Asylum about the year 1820 (7).

At Gütersloh every doctor and every nurse was expected to take part in the therapy (8), and every patient was expected to occupy himself actively, indoors or out, unless he was quite unfit to do so. If one became restless or "unnecessarily talkative" he was immediately taken to a single room or put into a continuous bath "until he regained control of himself". This was not punishment but was to prevent the spread of disturbance in the wards. At our meeting in Cambridge last May we learned that a noisy patient might be removed from a ward meeting there, for the same reason—taken out however by fellow patients on their own initiative. The Gütersloh method was very firm, but it was combined with friendly rapport between doctor and patient, with early discharge and with after-care by the hospital. It had much in common with habit-training as we know it, which was for instance discussed at Carlton Hayes hospital during our home tour of 1953 (9).

The principles of Dr. Simon had embedded themselves in Holland, and it was there that we went in 1928 (10), led by Dr. Evans and by his opposite number Dr. H. J. Pameijer (11), who knew us well and was often over here. One surprising example of occupation therapy is in the famous street organs of Amsterdam (Figure 2). These, I understand, are each in charge of a physically handicapped man who looks after the finance, while the men who turn the handles and pull the machines belong to the city's mentally handicapped.

We saw the Gütersloh method practised in many Dutch mental hospitals on that first visit; we saw it in Germany later, and in 1930 we saw it again at Santpoort Hospital (12) near Haarlem, where over thirty of us spent three days on the invitation of Dr. Kraus who was then Medical Superintendent. Hardly anyone was unoccupied; there was one woman of 70 who had recently fallen on ice while working out of doors, and had broken her leg, and several others who were too excited or confused; but everyone else was working or trying to work, and the quiet orderliness was in impressive contrast to the pandemonium which one sometimes saw elsewhere in those days.

In 1934 we were taken to see how occupational therapy had developed in England and Wales (13). Among the places visited was Dorset House in Bristol, under Dr. Elizabeth Casson. Whereas the Germans and Dutch, together with Dr. Evans, believed that the nurse should be the person concerned with occupying the patient, Dr. Casson was impressed by the need for trained professional therapists. Her school for them at Dorset House was the forerunner of six others, and itself progressed to become the Dorset House School of Occupation Therapy, now associated with the Churchill Hospital in Oxford.

In the early days we were all interested in occupation therapy. In 1933 the Board of Control published a report on it (14); in 1932 the College of Nursing, with the Maudsley Hospital, organized a course in the subject and in 1938 the R.M.P.A. published a brochure thereon as a supplement to its *Handbook for Mental Nurses* (15).

Industrial work is in the foreground now, and in 1960 the report of the Ministry of Health (16) stated that it seems to be the most effective means of rehabilitation. Lately the emphasis has moved from the hospital to the community and much thought is being given to sheltered workshops such as we have seen in Holland, and to junior and adult training centres and various industrial schemes.

The recommendation which has most newly come to my notice, but a very ancient one in time, is in a book included in the fine collection which the Royal College of Physicians has set out for us to see during this week of our Annual Meeting. It is the "De proprietatibus rerum" of Bartholomaeus Anglicus (1481) who, writing of those afflicted with madness, says that "they must be gladded with instruments of music and some deal occupied" (17).

Hospitals, Doctors, Research and Treatment

When we were on tour great attention was always paid to the design and furnishing of hospitals (18) (Figure 3); two of our party in 1949 commented especially on the timber furniture and ironwork in Sweden. Many

doctors and architects have visited Sweden recently and have come back stimulated by what they have seen.

We used to argue about details of structure with our hosts as we walked from the laundry to the kitchen, or from the admission ward to the tuberculosis ward. We borrowed many ideas from each other. We did not greatly like the combined "day-dining room" because we felt that as patients spend most of their day in their own wards, they should have a change of scene at meal times. This is less important now that patients move about so freely within the hospital and outside it; and certainly the space and light which modern architecture can get into a day-dining room is very pleasant.

There is one feature about which we have learned from Scandinavia, Holland and Switzerland, the ward partition. When I was young, we of the Board of Control used to visit what were then "the workhouses", to see patients detained there. We were pleased when an authority was progressive enough to pull down the big wooden partitions to let in light and air. Pictures were taken down too, they "collected dust", and indeed some of them were extremely gloomy. So we came to the era of large bare wards. Now we are putting partitions back again "to give a sense of comfort and privacy". It must be admitted that in design and materials they are much more pleasant than the old ones. It was the long dark gallery wards of the old Bethlem Hospital, with their Victorian furniture, which produced what our Dutch visitors described as a "morose-genteel" atmosphere (19).

We met, of course, many doctors, and I would mention Dr. Gjessing of Oslo, to represent them, though there are not many like him. He and his faithful staff, "working like desperadoes" (20) carried out the most detailed and painstaking researches on selected patients, on their weight, sleep, pulse rate, blood pressure, saliva, urine, haemoglobin, basal metabolism and mental state. The workers even recorded the movements of patients in bed, by using an adapted seismograph. The task went on day after day, year after year and "gave an enormous stimulus to research in this field". During our tour of Scandinavia in 1949, Dr. Gjessing made a special journey from the farm to which he had retired, and gave the party a talk on this famous work on nitrogen metabolism in periodic schizophrenia.

Like the gerris, the water-skater leaping from pool to pool, or like Hanuman leaping from the Himalayas to Ceylon, we must now leap from Norway to Wales. Another mountainous country this. The mountains of Wales figure in our records. Describing the Dutch study tour of England and Wales in 1929 Dr. Evans wrote, "leaving the coach . . . we climbed, some more, some less, up the track towards the summit of Snowdon in order to obtain a view. . . ." How like him it was to take those from Europe's flattest land towards his country's highest mountain!

Research was carried on in Wales from an early date. After a conference initiated by Dr. Edwin Goodall of Cardiff, later our President, the Treasury in 1912 placed at the disposal of the Board of Control a sum of money to be used in aiding research during the current year (21). In 1913 the Psychiatric Section of the International Congress of Medicine held in London made a special excursion to Cardiff (22) to see the research in progress there. Under such men as Quastel and Richter the laboratories there at Whitchurch Hospital have continued to do notable work, especially in biochemistry. It is noteworthy that the idea of the Mental Health Research Fund originated from that laboratory.

The next country to mention is Switzerland. Here was research of another kind, namely psychological research, which became known all over the world, though its author died young, before his tests had become generally accepted. They were the "psychodiagnostic" cards of the Rorschach test (23). Eugen Bleuler said of Rorschach that he was "the hope of Swiss psychiatry for an entire generation". He was about to become Oberarzt at the Burghölzli Hospital in Zurich when he died. We have more than once been to Switzerland, and to Burghölzli, which is now the University Psychiatric Hospital. When we visited it in 1952 (24) we heard of clinical research which

also became widely known. This was the careful and patient observation of the symptoms, the behaviour and speech of schizophrenics which led to a new and deeper classification. At the visit which I have mentioned we found as head of the hospital one who is now an Honorary Member of this Association, Professor Manfred Bleuler. He gave us an "historic lecture" on the development of the theory of schizophrenia by his father, Eugen Bleuler.

In 1938 we had been in Switzerland to study Sakel's hypoglycaemic shock therapy; this is the tour recorded by photographs taken by Dr. K. K. Drury; there is a lovely picture of Münsingen Hospital near Berne, where this treatment was in use; the Bernese Oberland is seen behind the buildings. We had not gone to Austria at that time, because the political sky was too clouded. But I shall allow myself for a moment to leave as it were, the study-party, and go in memory to my visit to Vienna in 1936 where I had been sent to study the insulin treatment (25). It was even then a time of great tension. Anxiety was rife—it was during the rise of Hitler—among an Austrian population which included Jews and Catholics, Nazis and Communists. Fierce currents of political feeling swept the city, distorting even medical opinion in the Allgemeines Krankenhaus where the treatment was developed. Sakel had his own way of expressing his feelings about this; he had a yellow overcoat of dramatic cut; he told me it was his "Gigolo-mantle" and said that he wore it to startle the sober clinicians who did not agree with him. In this atmosphere, how was I to find the truth? After hearing all sorts of opinions about the new treatment I finally reached a favourable view of it, partly from discussion with its sponsors, but largely from what I was told one quiet Sunday afternoon by patients who had improved after a course. Earlier, one of my colleagues had written in his notes, "If the claims made are true, this is the discovery of the century". As recently as April of this year Professor Ødegaard of Norway, speaking here at the Royal Society of Medicine on Psychiatric Epidemiology (26), said that the rise in the discharge rate from mental hospitals began when the hypoglycaemic treatment became established. Yet the high claims made by Sakel were not justified and the treatment has been almost entirely given up. What then did it do for the patient? Some pharmacological effect it must have had, but surely the main effect was psychological. In the hospitals we doctors changed almost overnight from being psychiatric well-wishers into real physicians in white coats, ready to administer intravenous glucose; nurses too became short-sleeved busy people with drugs or syringes in their hands. We were lifted up by new purpose. "Beware of enthusiasm" you may say . . . but "Beware of accidie, of indifference!" say I, for our very optimism did good.

Then in 1937 Dr. Rees Thomas and I were in Budapest to look at Meduna's convulsion treatment by cardiazol (27). We saw a catatonic schizophrenic carried in for his second cardiazol session. "That man is different!" said my colleague, and indeed he was obviously more alert than he had been the day before. Here again was the sudden bright gleam of hope, and hope shone also through the clinical statistics. You who are young in psychiatry can hardly imagine what that meant to us. Insulin therapy and cardiazol made the first cracks in the black ice which held us powerless in that era. You may remember that as late as 1946 Sir Lawrence Brock in his Maudsley Lecture (28) spoke of the "profound pessimism" which characterized psychiatrists, though as he said, things were changing and "the dawn was breaking". Treatment has gone on fast and far since then, and now as we float on the tide of 300 tranquillizers, it seems incredible that we were once so helpless.

Community Care, Tours at Home, The Care of Children

If community care is as new as our Mental Health Act, it is also as old as the sixth century, if Belgian legend is to be believed. There is one outstanding personality to represent both Belgium and the care of patients in families—St. Dymphna of Gheel (known since the

Flemish spelling reform as 'St. Dympna of Geel) (29) (Figures 4 and 5). She was an Irish princess who had been baptized as a Christian. After her mother's death she refused the incestuous advances of her father, who was inspired by several devils. She fled to Belgium in a small boat, accompanied by a troubadour and his wife and by the monk Gerebernus, and, says the legend, they were guided by two angels. They reached Gheel, near Antwerp, and there lived, beloved by the inhabitants, until the Devil told the King where they were and he followed them and cut off their heads. Their relics became a centre of pilgrimage for the unhappy and the insane, who were to be cured thereby. But this did not always happen, nor all at once, and so it came about that some of the pilgrims were boarded out in the village, and later a hospital was built for them. Thus grew the famous "village of the insane". However, there has been a considerable change here in recent years (30, 31). Dr. Rademaekers, the Medical Director, has kindly sent me some up-to-date figures. In 1930 the number of patients in hospital was 150, increasing to 250 in 1951 and 378 in 1961; over the same period the number of patients boarded out fell from 3,000 in 1930 to 2,400 in 1951 and 1,881 in 1961. In 1951 the total population of Gheel was given as 18,000. The drop in the number of those boarded out and the increase of those in hospital has been attributed to the lessening of the need for the work of the patient in house and garden, now that the standard of living is higher; to the failure of payments for patients to keep pace with rising costs; and also perhaps to some weakening of the sense of vocation among people whose families for generations have had the care of patients.

We had one of our tours in Scotland mainly for the purpose of seeing something of the Scottish "boarding out" system (32, 33). Dr. Douglas McRae (34) said that in 1900 the "number of pauper lunatics in private dwellings had reached nearly 24 per cent" of the total registered number. The trend of events since is shown by information supplied by Dr. Laura Mill of the (former) General Board of Control for Scotland. In 1931 there was a total of 2,601 boarded out patients, which at 2,698 was even higher in 1961. But while from 1931 to 1961 the number of mentally deficient patients boarded out increased from 1,124 to 2,442, the number of boarded out mentally ill patients dropped from 1,477 to 256.

But comparisons in our own country have been bedevilled by changes in administrative classifications and by new terminology. Long ago in a Sussex garden I found Lizzie, a cheerful imbecile, hiding behind a water-butt; she had been taught to run and hide when visitors came from the Board of Control, for she was of good family and they did not wish her condition to be known. Nowadays there are no "imbeciles" and no Board of Control, and for various reasons many patients who used to be on a Local Health Authority's guardianship or supervision list are no longer reckoned as "patients"; they are "people" on whom the Authority keeps a friendly eye. Let us hope that the Lizzies of the present age continue to be well cared for.

We have seen family care on our tours in Holland, France and Germany; but the prime example is still Gheel, with its active work, its relics and its scars of battle. Not only Dymphna and Gerebernus were killed there; it was fought over three times in the last war and the cemeteries near the church hold the graves of our men of the K.O.S.B., the K.O.Y.L.I. and other regiments.

There was a later tour in Scotland than the one just mentioned. In 1958 a party of us travelled from Carlisle via Dumfries, Glasgow, Inverness, Aberdeen, Perth, Edinburgh and Melrose, back to the South again. What we saw on this tour has been described (35) and so has what we saw on our tour in England in 1953 (36). For a really full description of the latter I commend you to the article by Professor de Busscher (37) who was with us. I shall not here give the details to be found in those articles, but may say that it is most refreshing and revealing thus to visit hospitals which one has known on more mundane occasions, and that it has been of great professional help to me to have learned on these tours about advances in electroencephalography, biochemical research, nuclear sexing,

paper chromatography, somatotyping, habit training, building work by patients and much more.

Returning now to the care of patients, and in particular to the care of children, we may think of France. There in 1799 was found a "wild boy" who was taken by some hunters in the Aveyron Department as he was escaping into a tree (38). The care given to him after that foreshadows the best modern care of the deprived and the handicapped. He was described as "a degraded being, human only in shape, a dirty scarred inarticulate creature who trotted and grunted like the beasts of the field". Jean-Marc Gaspard Itard, physician to the Institution for Deaf-Mutes, undertook his education, and after two years the boy was "almost a normal child", clean, affectionate, even able to read a few words. It is not only isolation in the forest that can deprive a child of warm human contacts. The Wild Boy of Aveyron had at first spent his time rocking himself backwards and forwards; just such behaviour was seen in the child "Monique" in the film which we know as "Maternal Deprivation in Infancy" (39) by Madame Rondinesco of Paris. When we visited France in 1929 we saw something of France's care for children; our report has three pages (40) on the "Patronage de l'Enfance" for the protection of children in all kinds of adversity. There was first some psychological examination of children and later the Patronage had opened for them a neuropsychiatric clinic and out-patient treatment facilities. I should like to mention, too, the mental health work going on in Paris under the delightful name of *L'Elan Retrouvé* ". . . joy, zest, vigour, rediscovered . . ." what a sparkling phrase to use instead of our bookish "rehabilitation"!

Delinquency Laws and Cultures

From the Wild Boy we move to wildness of another kind, namely delinquency in the subnormal. Some of us saw the treatment of this in the beautiful island of Livø in Denmark many years ago. The 2½ miles of sea between the island and the mainland was a deterrent to would-be escapers, except on the rare occasions when the sea froze over. We did not visit this place on any tour; some of us saw it on a private visit, in the company of the late Dr. H. O. Wildenskov who took much interest in what we were doing in this country with the like patients, and even submitted comments (40) to the Royal Commission on the subject. The Zeitgeist has visited Denmark, however, the wind of change has come and Livø is no longer used for subnormal patients but for voluntary students of agricultural work (41).

There is other work on delinquency going on in Denmark which is even better known; that of Dr. Stürup at Herstedvester. We saw it in 1949 but did not say much about it; I therefore take a brief quotation from a report by Dr. Aungle (42). As so often in Scandinavia it is the architectural aspect which shows the spirit of the work. Dr. Aungle wrote of six isolation cells in this old institution. "They are the only ones seen by the writer which accord with the principle that isolation should be strictly a measure for the protection of the person concerned and others, and not a vindictive retaliation" . . . "larger windows than an ordinary cell set lower down and looking over one of the main thoroughfares of the institution". In this hospital there was an open unit of 30 patients. In Denmark it has not been unusual for feebleminded youths and maidens to be sterilized and then allowed to marry and set up house, which they can manage successfully when they have not the care of children to cope with.

We have gone far on our journeys and have not yet mentioned those on whom falls the great burden of caring for our patients, the nurses. In almost every study-tour report nurses, nurse training and nurse-patient ratios are mentioned; but the figures are now so out of date that it would serve no purpose to give them. Our most difficult patients are cared for in Broadmoor, Rampton and Moss Side; but there is only one of these which can properly be said to have been the object of a study tour, namely Rampton. In 1934, by invitation of the Board of Control, about 120 persons, mostly members of our Association,

visited the hospital; that was one of the earliest activities of our Mental Deficiency Committee, which afterwards developed into the Mental Deficiency Section (43).

Our latest tour abroad was in the Autumn of 1961, and was to Israel. I shall say little of this tour, for there will be a published account for you to read. I can say that the visiting party were struck by the many cultures in that land, desert tribes, sophisticated Middle-Europeans, people of the most varied languages, laws and customs. It was a very successful tour.

The most recent developments in England have been those associated with the Mental Health Act of 1959. Laws about the mentally ill go back a very long way. There is one of 1224, from Heidelberg, in the old Sachsenspiegel (44), which sets out the duty of a guardian to be responsible for the deeds of a fool under his care. It is a long way to the "open door" policy and the "new look" in mental health, with its emphasis on the community rather than the hospital. Let us not quibble about who thought of it first; the principle of more freedom for mentally ill people goes back to the Tom-in-Bedlam inn sign, with "Tom at Liberty" on one side of it, and to Pinel, and many others. It is the move towards the open door, which is bringing visitors from all over the world to see the work which is done here, and which in one sense, we have only just begun.

The Gains

I have only now to sum up what we have reaped on our psychiatric journeys. That can be done in few words. To the young travel can be a revelation, in the words of one "the most wonderful experience of my working life". To those who come to travel from years of close application to the work of their own hospitals it gives a new and broader orientation and new inspiration. I myself, not young, have had great pleasure, have made many friends, and found new insights, contacts and sources of information which have been useful to me over and over again in my official work.

The tours are narrow bridges, but they do enable us to take from country to country messages of professional understanding and good will, which can cheer and help us all. Our gains cannot be measured. They crowd the notebooks of the enthusiast and creep unnoticed into the mind and heart of the sceptic who thought that he could learn as much from his books at home. We owe more than we can say to the seeds of travel sown by our Association thirty-five years ago.

Acknowledgment

My grateful thanks are due to the following for the loan of material for the slides shown during the delivery of this Address: Drs. Hamargren, E. O. Lewis, B. Finkleman, K. K. Drury, Ilse Torgard, Mildred Creak, R. Ström-Olsen, J. P. Spillane, A. D. B. Clerke, and S. MacKeith, Miss Dunkley, Mr. H. O. Wildenskov, the Municipality of Amsterdam, the National Trust, the Ministry of Health and the Israel Travel Agency. For the illustrations relating to St. Dymphna I am undebted to the late Dr. Sano.

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