THE COHEN INTERVIEWS

MOLLY BREE -- Interview no 5.

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Each interview is presented as a free-standing publication with its own set of notes. However, readers interested in the Cohen Interviews as a whole and the period discussed are referred to:

(a) the other 25 interviews

(b) the Editors' Introduction,

(c) the select Bibliography.

All of these can be found at:
http://www2.warwick.ac.uk/services/library/mrc/explorefurther/subject_guides/social_work

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Molly (Hettie) Bree (1900 --1994**).** There is relatively little in public records about Molly Bree and the Cohen interview captures a career history that might have otherwise been lost. There is uncertainty as to what the diminutive 'Molly' stood for with one source giving 'Mary' and another offering 'Muriel'. However the interview clearly records her professional interests and her progress from junior cashier in an insurance office to training in Birmingham and then a place on the LSE Mental Health course in 1937-38. From then on as a PSW she clearly gained the confidence of eminent mental health specialists such as Sybil Clement brown, Margaret Ashdown and Sir Aubrey Lewis.

The interview has many vivid and telling anecdotes -- lunchtimes at the Canonbury Child Guidance Clinic saw the ten students crammed into a hut at the end of the garden while the two tutors ate more graciously in the house. And she was obviously not impressed by the LCC's Asylum Committee who would travel down to Epsom on a certain day, have lunch, rubberstamp the medical superintendent's recommendations about patients and then go home. It was in the long stay large mental health hospitals that she did her best work after an uncertain reception:

> “I do remember going and complaining to Janet Jackson that life as a PSW wasn't quite what I thought it might be and that there didn't seem to be any point in what I was doing. She reminded me we were pioneers. I hadn't thought of myself as a pioneer, nor much liked it. If you are a pioneer, you can't have a structured, clear position, but that's not the same as being unrecognised as a pioneer or even existing among thousand, who all had their proper places.”

Readers wishing to research Molly Bree’s career sold consult her The Function and Use of *Relationship between Client and Psychiatric Social Worker*. [BJPSW 2(6) 1952] and *Staying the Course* [BJPSW 10(4) – final commemorative issue] in which she reviews her own training and experience as a PSW.

A third Molly Bree publication *The Dement in the Community* was published by the Horton Group Hospital Management Committee and earned a Foreword from Sir Aubrey Lewis. Just as we were going to press, Jill Manthorpe kindly sent us a copy of her paper *The Dement in the Community: social work practice revisited* which examines the original Bree paper and provides commentary and reflections on how social workers approach services to people with dementia and their families.

A.C. When did you come into social work?

M.B. Paid, professional social work? Not until I came out of the Mental Health course **[1]** at the LSE **[2]** in 1938. I had my Social Work Diploma. I'd always been doing voluntary social work, along with my own job. I think there were people around practically always with some sort of trouble.

I can remember very early in my teens, that a man whom I admired enormously who was a sort of speaker for the Salvation Army, got into some sort of trouble and came to ask my mother to write a letter for him. My mother found it too complicated and asked me to do it. I think I always help when people come, or try to. My main motive, I think, is a kind of indignation for the unnecessary waste that goes on in time, money and thought and especially of spirit. People get letters they don't understand, or someone makes a mistake, and it snowballs from there, so I quite like having a bash. It seemed to me that I saw so much distress, so many troubles, flowing from one thing to another, not always in practical matters, that I did think I would like to qualify.

A.C. What was your job?

M.B. I'd been a cashier before that and always dealt with money in an insurance office. I didn't want to take the insurance exams because I hadn't matriculated (that is, passed the required exam subjects) for one thing, and it would have been too big a bind for something I wasn't particularly interested in, so I decided to train for social work when I had saved enough money. I didn't go until I was thirty, so I was rather late really.

A.C. There were no grants?

M.B. Not grants as understood today. I won a bursary, then I got the Social Work diploma at Birmingham University and realised that it didn't qualify for very much, so took the Mental Health course. Without thinking at all of wanting to work in mental health, I realised that it did give a more advanced kind of approach to things. The bursary was from Woodbrooke, **[3]** a unique college-cum-settlement of the Society of Friends, which enabled me to live and take part in all the life there but specifically to take the Social Work Diploma course at Birmingham University, and matriculation wasn't obligatory. I suppose getting the bursary indicated sufficient ability. Perhaps I might add that I gained the first distinction given since ten years before. I find some people tend to think that the academically able don't tend to stay long in the directly-practical, personal social work, which we were then trained for.

A.C. What year are we talking about?

M.B. From 1937 to 1938 I trained for Mental Health at LSE, so this was about 1934 from the Social Work course to the Mental Health course, so I didn't have a paid job as I said, until 1938. I never again had the money that I'd had in insurance and commerce.

A.C. Can we go back before the decision to leave the insurance company, when you said you got involved in social work as a volunteer? Was that through an organisation? What happened?

M.B. I ran clubs; it was a practical, outgoing sort of thing: running socials, collecting money, all sorts of things.

A.C. Youth clubs?

M.B. Yes, but they weren't called that then. I think it was a Blue Triangle Club **[4]**, connected in some way to the YWCA, and I took groups on holiday. I was once a Sports Mistress. I took them out for a swim. I couldn't swim enough to save anyone! But that's the sort of thing I did.

A.C. Was this in London?

M.B. No, I lived in Leicester, where I was born, until 1930, but I have worked in London ever since the Mental Health course.

A.C. Did you have any connection with the COS **[5]** in Leicester?

M.B. Never. I realised gradually that it would be very worthwhile to be able, as a qualified person, to go to these various authorities about things in people's lives that seemed to be in such a muddle – an unnecessary muddle. You see, I only heard of them – the muddles and the worries over them – when they had got so entangled. No doubt, ninety-nine out of one hundred of the same things went straightforwardly, but I seem to remember, even in those days, being able to get someone the pension when they were sixty-five.

On one occasion, they had letter after letter saying they couldn't have it but when you listened to the story, there seemed no earthly reason why they shouldn't. When you looked at all the letters, you would find something odd. Although each letter on its own might seem sensible, if you took it up, it got settled by getting the whole

sequence of correspondence seen to as one problem, not each letter as a separate, unconnected transaction, as often happened.

So my idea of social work was this sort of thing. Such things came to me as to a friend by someone in tears or obviously not in his or her usual spirits, expecting sympathy with their bad luck and a sharing of their annoyance and an understanding of their unhappiness. Certainly not to get the matter remedied! I was doing this sort of thing all the time in book-keeping, banking and accountancy; checking, tracking down, cross referencing. I never thought of there being anything psychological as absolutely separate from these conditions.

It didn't seem at the end of the two-year course that I'd learned a tremendous amount. As I look back on it, I don't understand why, when the generic course idea swept all before it, there was such a repudiation of the old Social Work courses **[6]**. Some people said some very contemptuous things about them, with the kind of contempt that always 'alerts' me as a PSW. I think I felt about the Birmingham course, that I hadn't really learnt anything to enable me to go straight into anywhere to function helpfully. I think in my case, I felt the lack of familiarity with the structure of any social service institution, a familiarity that all the university-acquired history of origins, purposes, practices and high-up administration, can't give you. You have to be a part of it.

A.C. Was there a tradition in your family of social work?

M.B. Not in trained social work, but certainly a tradition of voluntary work. If anyone was in trouble, we tried to sort it out for them, yes.

A.C. Had you worked out a kind of religious, political or philosophical position on all that, or was it just part of you?

M.B. No, I think I rather looked upon mother as 'Mrs Wiggs of the Cabbage Patch'. Do you know the book? This was a book read in my day, about an American woman with a kind heart who looked after everyone. Her children, the Wiggs children, would grumble because they would come home to a note that their mother was missing, as someone had come to fetch her to a crisis. This American character lived in a cottage called The Cabbage Patch. We, my brothers and I, did sometimes complain, but there were always other children around and we were pretty self-sufficient at amusing ourselves. My mother wasn't qualified or anything, you see, but there was a sort of spirit that if someone was in trouble, you went if asked.

So I am not really the material of psychiatric social work but got into it by one way or another. Perhaps the unsuitable people and the untypical placements had their own suitability!

A.C. Yes, I suppose they did. What I am getting at is: was there a driving force? Was it Christianity, or Humanism or Radicalism – something like that? Why were you all like that in your family?

M.B. I don't know.

A.C. I've heard some people I've spoken to refer to the period following the war as the period of great idealism, and a lot of young people then, determined to make a better future, being caught up in all that.

M.B. I don't think I was thinking in those terms. It was a very religious household – extraordinarily narrow. My parents were members of the Strict and Particular Baptists. If anything, they were or would see themselves as in this world but not of it. They would certainly not think good works were a passport to anything else. After all, they accepted the doctrine of predestination. It was just that my mother had a very kind heart. Therefore, it was unthinkable not to help if it came your way, but certainly we didn't think of going out to look for it.

I don't like waste and I have a feeling that rather than be thinking in terms of idealism, I didn't like to feel that somebody hasn't got what they should have, because of the carelessness, indifference, incompetence or stupidity on someone else's part. It's an unwarranted assumption that an official, or older person, or someone more educated, must always be necessarily correctly vis-à-vis the someone not 'dressed in a little brief authority'. What agonies this has been responsible for, in my experience.

Perhaps I'm particularly alert to this because my earlier training and such qualifications as I had on book-keeping, accountancy and keeping and preparing a balance – and your balance had to be right – had to cover all relevant factors, and you couldn't cheat. I carried that over into social work. There is no way of saying a thing is something else if, in your own mind, you know it isn't, because at the end of the day, it won't balance. It is the only policy, because otherwise it won't balance.

A.C. So you did Social Science Certificate at Birmingham? What was that course like?

Well, it would be very difficult to tell you in a sense what the university course was like, because I got a bursary, which involved living at Woodbrooke. Now I don't know if you know anything about Woodbrooke but in Birmingham there are a series of colleges called the Selly Oak Colleges. There is a Missionary college, a YWCA Training college, Carey Hall for Education, and somewhere for Religious Education. Woodbrooke was founded by a Rowntree for Quakers and others to go for terms to study Quakerism and International Affairs and so on. They also had people who lived there, participating as much as they could but studying for degrees at Birmingham University. There was a bursary going and I got it. I got far more out of living at Woodbrooke and studying there than I did from the University. We had a tutor especially for us, while the big majority of people taking the Birmingham Social Studies course lived at the Birmingham Settlement. **[7]**

There was a very famous warden there at the time and her students lived in or around the Settlement and did there practical work there. We, up the Selly Oak colleges, a few at Woodbrooke, a few at different colleges, had our practical work arranged for us and took some of our lectures through staff connected with the Central Hall, which had a unifying role among the Selly Oak colleges.

When I was there, Woodbrooke was taking a great number of refugees from abroad. It had always taken overseas students. In one of my terms, there were thirty-seven countries represented by sixty students! The refugees had student-status while

something was being done about arranging some next step. Many went to posts in American universities, a few were found Fellowships at Woodbridge, but among these 'students' were professors, lecturers, a judge and an ex-minister in the Weimar Republic. Such a list! That was a great deal more than of an education than the Birmingham University lectures.

These lectures were not part of a Social Work department. You took different subjects with people into whose department you were allowed to go, and built a social work education from this and from your practical work, and from the help of your tutor and lecturer on purely social work subjects, at Selly Oak.

We had Economics with the Economics degree people, Law with the Law students and Psychology in the Education Department with the budding teachers. You made a course out of the whole jumble. Looking back, I couldn't say that it wasn't extremely useful.

But at the end, I had expected to be able to walk into some job with all the knowledge of the way the institution actually worked and how my particular job fitted into it. That's the way I had learned book-keeping, for instance, and expected to be able to take my skills from one situation to another. But in the end, you see, it had been very theoretical.

A.C. Did you have classes and seminars?

M.B. Yes, we had seminars and discussions on practical work.

A.C. What sort of thing did you argue about in the seminars?

M.B. I honestly can't remember. I remember so much more of our discussions at Woodbrooke with people who had come over from Germany, Africa, Lebanon and Sweden than I can about the University itself.

A.C. What were those discussions about?

M.B. Everything.

A.C. A wider, more outward-looking thing?

M.B. Yes. I did go to lectures on religion there, because they were fascinating, but philosophy and the international situation was an opportunity unlikely to come again, as was struggling with generalities to describe unimaginable experiences. Many successful, well-qualified, middle-aged men who had escaped or been deprived of nationality after physical torture, were grateful to be among friends and were prepared to give what they had learned from their experiences, which challenged their (and our) previous values and judgements. That was probably the most formative influence of any in my life.

A.C. How did you come to hear of the LSE Mental Health course?

M.B. I just saw a leaflet or something at the University. Not a soul there knew anyone who had ever been. When I went, I didn't know a soul. This was unusual I discovered when I did go. There were several students who already knew, or knew of, the tutors.

They knew what happened and what was what. I simply knew nothing. I think it was more that I didn't know what I knew in relation to other students and my tutors' expectations.

A.C. They were insiders?

M.B. I didn't know what would happen, for instance, how one was selected. I thought that psychiatrists – I'd never seen one – must have a sort of x-ray mechanism which showed whether a budding PSW was in their presence to be 'developed' or not. I didn't see it as a matter of pride or shame to be selected or rejected.

I remember being very frank with Clement Brown (Interviewee no 7) whom I saw first, and saying that I was much too old to want to get selected for something I wasn't suitable for. She asked me what I would do if not selected and I said, "Take tests at the…" (I've forgotten the name) but it was quite a reputable organisation, which tested for aptitude and personality and so on. Clement said she would be very interested in the results. I was only going to do this if I wasn't selected for the course. I was very hard up by this time. I don't remember her exact words but they conveyed the feeling that she wouldn't be surprised if I were selected.

Then I remember being interviewed by the Director of the Child Guidance Clinic who was then Doctor William Moodie **[8].** He said, "Sit down" and I sat down and it was one of those old-fashioned settees, like a feather bed. For the first few seconds I thought, "This is a test as to how I get up" as I was practically on the floor. Sagging springs, I think! I forgot about it after a few seconds. He was just a man.

A.C. But you felt pretty scrutinised?

M.B. When I went in I did. I had been told so many stories by this time about how 'they' psychoanalyse you. Students did talk in those terms at that time. I think what people forget is that the minimum age was twenty-five and it was very rare to accept anyone at that age. The year I did it, we had four people over forty and the big majority were over thirty. They had all done jobs before and I, and many people of my age, had already read Freud and Jung and those people, long before I went in for psychiatric social work, so that some people connected with the course quite mistakenly seemed to expect that everyone was sure to be bowled over by the course. I don't think you would have been, unless you were ready to be.

A.C. You had read them before the Birmingham course even?

M.B. Yes. The books were reviewed when translated. The ideas were in the air. I remember going to a course of classes in about 1932 on 'A Freudian Interpretation of Hamlet' whilst still a cashier! The difference in training of course, was that you had to come face-to-face with the concepts in your own personality, as it might affect your work, but it meant that you have gone some way towards this before taking the course. Vitally important to have it in and during the training, of course. I think what was a bit disturbing was not knowing what you had qualified in, whether it had been an academic year or had been in practical work, or whether people just liked the look of you.

It was difficult in this respect, compared with an ordinary course. I think, as in almost any other course, the value (I must be careful as I owe an enormous amount to my tutors) was in how much we students taught each other or helped each other in our muddles in thinking and learning, in spite of the fact that we collected, received and spread an enormous amount of nonsense about things we couldn't really know about in our student position.

Our dining room at the Canonbury Child Guidance Clinic **[9]** was a hut in the garden. You ordered sandwiches in the morning to be delivered at lunchtime by the local Express Dairy Company. The staff had theirs in the house and we had ours in the hut. The difference between us, being students under tuition and supervision in the house and us, on our own for an hour, munching away in the garden, was hard to describe. Like children going to the bottom of the garden to play with no grown-ups in sight, yet 'talking shop' all the time and being desperately serious under the hilarity and irreverence. We let off steam, were awestruck and irreverent all at the same time. No doubt we did help each other.

I don't think we really talked about ideas and so on, except as linked to personalities, and everyone talked. Within the first week we all 'knew' all about the various tutors, their ways of dealing with things and so on. There were two tutors at Canonbury and twenty of us in the Course altogether, so we were divided into ten at the Child Guidance Clinic for half the year and ten at the Maudsley, **[10]** and the ten at the Child Guidance was then divided into two fives.

One tutor was said to be a warm, cheerful, practical person who didn't worry you a lot. The other tutor was most likely to spend all her time 'winkling' things out of you. I got the 'winkler'. It's true that if you were anxious about being 'winkled', that would happen. I got a lot out of her and liked her immensely. I can remember that we talked about books and my interests and my cases, in that order.

My cases… when I had any! I think I only had two cases and I don't think I ever bothered to tell people, so I didn't feel I'd learned enough to go out into Child Guidance. You see, I would have had to go out and be the only PSW in the team and I'd only had two cases. It wasn't anyone's fault. On one occasion, a person didn't turn up. Everything was so structured that if that happened, they couldn't give me anyone else until it was decided that it was not going to be a case. Then I had to wait until something suitable for my needs at my stage of learning came along.

A.C. That's two cases in six months?

M.B. Four months, because we had a ten-month course and we did one month studying Mental Deficiency and one month at the end of the course in either the Child Guidance or Maudsley at one's own choice. No-one ever commented or seemed aware that I only had two cases. Yet they must have been aware, especially when they got together to make a report to the Mental Health course. The tutor-supervisor wrote it but embodied it in the opinions of other staff. I got a very good report. It was read out to me. I was a wonderful, potential Child Guidance Worker – on only two cases!

A.C. Who was your tutor?

M.B. Nancy Fairbairn. **[11]**

A.C. Who was the non-'winkler'?

M.B. Miss Loudon or Lowden **[12]** I don't remember names much – then there were ten taken by Miss Ashdown. **[13]** I think it was a great pity that so few people now realise what Miss Ashdown really meant to the whole Association **[14]** and to everyone concerned in it, because the *Journal* didn't start until 1947.

From 1929 to 1947 Miss Ashdown had more influence on people's attitudes towards PSW work than any other single person but because she retired and didn't write much after that, we don't hear of her. She didn't mean a great deal to me when I was a student. She was already very deaf even in those days and either I wasn't much trouble and therefore there was no need for her to take much notice of me or I was dull, I don't know, but I didn't seem to have very much to do with her. I can remember just one tutorial: I thought it was absolutely marvellous and in that half-hour I got enough to last me my life about certain things.

Then she wrote a book **[15]** with Clement Brown (Interviewee no 7) and I happened to get included in that, coming into that series of years. They sent out written questions inviting written answers – 'free-er', more natural answers than one is able to give to the usual questionnaire. In the book they naturally made their own comments on these answers, the people concerned being made scrupulously anonymous.

At one point, they sent the relevant snippet of an answer-and-comment to the ex-student and asked for their approval of this being printed, or for further comments and objections. I remember that I was referred to about three times, always in a very warm, approving manner. But they seemed to me to have made an assumption about something I had written, which certainly was not in my mind and didn't necessarily follow, and I said so. Margaret (Ashdown) asked me to go up and see her. We corrected or omitted this to our mutual satisfaction. I went to see her certainly once a month and we became great friends. I do know that other people got a lot out of her when they were students and I think it is a pity that later PSWs hear so little of her.

A.C. A lot of people have been saying similar sorts of things. The people I've spoken to, talk of Miss Ashdown in that way.

M.B. I'm glad, because it is so easy to read all there is written in the articles and not get the proportion right.

A.C. I was interested in your anecdote about her book. There's something of yours in *Social Services and Mental Health*?

M.B. Yes, she would write, "One student said…" and we could often recognise each other through the careful camouflage, because we had probably referred to the same thing in conversations after Association meetings or conferences.

Perhaps I should say somewhere that many of us attended APSW meetings as much to meet those in similar settings to our own and to pick each others' brains or get comfort from each others' dilemmas, as to participate in discussions.

By the 1950s, much of the subject matter was, we felt, not for us and the manner often repellent. We listened like hungry sheep who looked up and were not fed. Like the students in the Canonbury Square garden hut, we got together and helped each other out of such store of experience as we had (you could never stop feeling a student in the mental hospital field) and with quite as much irreverence, in the late 30s and early 40s.

The publication of *Dementia in the Community* was really due to Margaret. She would sometimes interject in our talks in the 50s and 60s saying, "Oh, I do wish you would write something along those lines. It does so much need to be said." Eventually, I told her about the study, which after a time, had been officially accepted by the Hospital, but there were many difficulties and delays and so much extra time had to be found, because after-care from the Hospital's point-of-view, was the least important port of call on my time. Eventually, Dr. Whelan couldn't give any more time to it and the medical superintendent suggested that I should continue alone. But the report, as printed, had only been envisaged as a foundation for something else and by the time I had brought it to that stage, there seemed no chance of anyone at all being interested. But Margaret thought some effort should be made, at least to get some opinion about it. It had been accepted by the Management Committee, perhaps as proof of how I had spent some of my time, but got stuck in the Hospital Secretary's drawer. Margaret asked if she could bring it to Sir Aubrey Lewis's **[16]** notice and the medical superintendent agreed. Well, Sir Aubrey was a name not to be ignored! Whether it was worth publishing in that form or not, it was certainly due to him and also through Margaret's efforts, that anything got printed at all. There was nothing you could call obviously 'active' about her or openly persuasive. She was a very great person and years later, in quite a different context, Sir Aubrey referred to her (in talking to me) as a 'saint'.

You were asking about tutors and I was going off the point. I remember that Clement Brown was alone at the LSE up to 1937. Then she had an assistant who worked part-time and only helped with tutoring. Her name was Janet Jackson. **[17]** and she took the course in 1932 and had spent some years helping with research at the Maudsley and took a year's course, I think in training and supervision. She certainly hadn't worked in a mental hospital. She was much younger than I.

There were all sorts of theories among the students who moved in the circles of 'those-who-knew', about who was allocated to Clement Brown and who to Janet Jackson. If you had Clement, they said, it meant you were either pretty first class brain-wise or you were very 'difficult' as a person and would need the experience of a really tough handler. If you were middle-of-the-road and not very interesting, or moderately easy to get along with and certainly with no 'difficulties', then it was Janet's first year you had her (or she had you). I regretted being second class in the beginning, as I would have liked to have had Clement Brown but at the end I would have said I wished I had been able to have both. I wouldn't have liked not to have had Janet, as she and I have been friends ever since, and I wouldn't have known her at all without our tutor-and-student relationship.

A.C. Is she still around?

M.B. She is, in Edinburgh. She left LSE in 1939 or 1940. Her husband took a post in America, then got caught there by the war and came over to Edinburgh some years later. She was never much in PSW work in Britain after that, I think, although she had done a fair amount of different sorts of social work. She too, is a really wonderful person.

A.C. Can you remember the sorts of thing you talked about in your classes?

M.B. Well, we had tutorials, so that to a great extent it was your cases from the point-of-view of general principles involved, as distinct from the personal aspect of yourself and your cases and their effects on each other, which you would talk over with your supervisors. If a general principle was involved, you talked it over with your tutor. If they set essays, you read your essay to them and discussed it. Then there was also this business of the individual seminar involving some sort of research and delivered to the whole group of students. The thing that was awkward for me was having had so little experience, being one of the few who had come straight from the Social Work course. You decided on a project with your tutor and supervisor and, with the help of cases from the Child Guidance Clinic or the Maudsley, you used your past experience of the same sort of difficulties you had encountered in your previous social work.

The weeks went on and I couldn't think of anything because I had never done anything in a recognised social setting. One day, one of the students who had been in Moral Reform **[18]** or something of the kind, told me over coffee what she was going to do and how it had got arranged and how I was getting on. I made my usual moan that I hadn't any ideas of my own and the list the tutors had prepared for such foolish students had now all been snapped up, and this student said, "What I would like to have done if I had dared, would have been on Homosexuality" and I said, "Well, shall I do that then?" She asked me if I knew anything about it and at that stage, of course, I said I didn't know anything about anything. She said, "Well, you can but ask, if you have the nerve!"

What is interesting now, looking back, is that we all seemed to think that the subject had to be one where you could find some cases as examples in the files of the Child Guidance Clinic or Maudsley. Because of what others were doing and how they got their 'starts', we assumed that homosexuality was a subject about which the tutors could look up some cases of homosexuality as a 'something' which could get you sent to a child guidance clinic or psychiatric hospital. This is in 1937.

I put it to Janet, who put it to Clement, and I realised there was a certain kind of wondering look but the verdict seemed to be, "Well, if you can't think of anything else, it's alright."

Then it was a question of having some cases. When Margaret tried to find me a few cases of mentally-ill people who had spoken of problems connected with their homosexuality, I couldn't see what they had to do with mental illness. It might just have been red hair or something else. It was in their history that they had been homosexual or said they had, but you couldn’t really see that this was the illness. This was very awkward for me, you see, because long before this I should have

been working on it and now, when I did find a theme, it wasn't really relevant, like studying certain problems found among schizophrenics, or anything like that might have been.

Time was getting on and Clement Brown said, "Look, this has been going on for so long and quite frankly, if you are prepared to do it, I would like a study. You can't find cases, so we'll do it a different way. Would you like to do your seminar on 'A study of homosexuality through available literature' and do it how you like?"

I think I spent the rest of the year with Kraft-Ebbing and all sorts of Germans and Havelock Ellis and Edward Carpenter **[19]** and the Bible, and everybody put little notes on my desk saying, "Have you thought of Jonathan and David?" or "What about so-and-so?" and someone else lent me all sorts of books.

I had so little time, and at the end, I had just a fortnight to look at all my notes on exam subjects. I felt so lucky to get something settled, whatever it was. Everybody was very interested and the students of the next few years seemed to know about it. It was really interesting because I didn't know a thing until I did it. 'Know' in the sense of reliable, systematic information. Of course, I was aware of all the snippets of vague titbits that pass for knowledge in subjects like homosexuality and venereal disease; the sort of false knowledge that causes far more problems than either of these conditions.

As I couldn't find any kind of cases and was always an omnivorous reader and came across so many speculations as to whether Shakespeare was homosexual or not, I eventually took the sonnets as my 'case'. I was still rigidly certain that I had to produce cases; everybody else did.

I've always been grateful to Clement for her lesson in adaptability. I can't remember much about it now but I had a lot of fun taking the sonnets just as poems and then all the different 'certainties' about them, written by different people whose own sexuality (or lack of it), was described or imputed by other people and accepted by themselves, and how the opinions correlated about the sonnets and the practices of the authors. I went really very seriously into it, starting with the animal world, the Bible references, social attitudes through the ages among primitive peoples, and Freud and Jung and so forth.

A.C. Was that not actually ahead of its time, in the sense that you were querying firstly, whether homosexuality was a mental illness anyway and, secondly, using literature as a source?

M.B. I was querying everything. I thought that's how you do research. It is one advantage of knowing one is ignorant; you suspect your own assumptions. You know they aren't based on knowledge when you get the chance to acquire this. I don't think anyone with whom I had any dealings over the seminar claimed that homosexuality was a mental illness. You must remember that the original suggestion came from a student, not from any member of staff, and she had been working on Moral Welfare. Doing this study certainly helped me in my work later on when I came across this particular family set-up.

I'm omitting the rest on this subject because I think your questions reveal assumptions not prevalent then within mental health hospitals or among serious workers in connection with psychoses. The widening and obscuring of the field of psychoses brought in all these suppositions that any deviation, from crime to unhappiness, were signs of mental illness. But this came later. This condition, regarded as repellent and untouchable, was more a question of hanging than of treating, when I did this study.

A.C. But in the other seminars that were held, were there disputes about what is mental illness? What is the right way of handling difficult situations?

M.B. We were, and regarded ourselves, as being students. We questioned everything and showed repugnance or confidence in respect to what we were learning about. How could we 'dispute' when we were only just being introduced to actual people in actual circumstances about which we had no previous experience? Only very rarely had anyone actual experience of working in the mental health field and then taken the course. That came much later.

This was 1937. So many people forget that if you have an Act, some of its new provisions don't become commonly-used for years after it's been passed, for example community care, compared with what it might be, seeing that it's fifty years since provisions were first embodied in an Act and twenty years since its importance was stressed in the last Mental Treatment Act**. [20]** In the same way, when I took my first job in a mental hospital, the term 'asylum' was only made officially obsolete by the 1930 Act, and the general public still used it. What's eight years in these matters? How many older people still call a five pence piece a 'shilling'? In the same way, many mental health doctors, later to be called psychiatrists, were dead against the provisions for voluntary patients to be admitted following the 1930 Act. No-one was compelled to admit them, for what seemed to them, the very good reason that they couldn't adequately treat someone who could give notice half-way through treatment and walk out.

They had only just started with something called cardiasol, which was given up soon after. There was insulin and the early form of ECT but no leucotomy yet. But the very idea of knowing that some you had just started to treat may be going to leave any day, and has the right to do so, meant that they often didn't get treatment. Whether this was just because they were voluntary patients, how can anyone be sure? Statements like that aren't written down. Often, the certified patient with a good prognosis got his treatment, such as was available, quicker in these hospitals, whereas in another hospital, they might really welcome voluntary patients.

Additionally, by the 1930 Act, you could have out-patient clinics, but whether a particular hospital got an out-patient clinic, depended on the local authority and not the hospital superintendent. In London, the mental hospital might be twenty miles away from the catchment area where the clinic would be, if there was one. It was in the out-patient clinic that you picked up the voluntary patient, so if, as in my hospital, you didn't have an out-patient clinic, the only way you got your occasional voluntary patient was from your own discharged but relapsed patient who was willing to come back, and by writing direct, or perhaps his GP applying for him. So there were very few voluntary patients in my work.

I was at West Park for four years **[21]**. It was a general mental health hospital, almost new, opened in 1925 and to which a very large number of treated, slowly-deteriorating sufferers from *encephalitis lethargica* from the 1917 epidemic, were transferred from surrounding hospitals. Many of these were grossly and physically distorted by the disease, and as they often couldn't move their mouths to form words, their mental health condition was hard to determine.

A.C. Where was that?

M.B. In Epsom, Surrey. Epsom has four mental hospitals; three of them were for two thousand patients each. The other, St Ebbas, which had an out-patient clinic in Battersea, had about five hundred patients and took mainly voluntary patients. My work at West Park was mostly with certified patients or, more euphemistically but not used by the patients themselves and their families, “patients under certificate”. I took histories where this hadn't been done at the observation ward, which was where the magistrate signed the certificate, and I undertook anything that was likely to be helpful during the patients' stay. As, and if, they recovered and were to go before the Management Committee with a view to going out on a month's trial under the care of their next-of-kin or other responsible relative, I paid a home visit and made a report as to the conditions to which he or she would be returning. Then I paid weekly visits during the on-trial period of (usually) a month, and then such after-care as I thought would be helpful.

There was another way of leaving hospital. When the patient was relieved of any dangerous symptoms but was not likely to recover, a relative could apply under a certain section of the 1890 Act. **[22]** I dealt with these too. To explain procedures: the departure of patients under this section, and the admission of voluntary patients, meant establishing that the family were not rate-aided (paupers) in the former case, and also that the patient had a settlement, or at least an 'irremoveability' status in the other case, which is far too complicated and really means going back to the 1601 Poor Law Act, [see note28 below]. PSWs were involved in ascertaining all this. It was all swept away, not by a new Mental Treatment Act but by the 1948 National Health Act **[23]** because immediately, in one day, there weren't any local authority rate-aided patients in hospitals. It was a national affair, no longer a local one.

A.C. I read that there were very few hospitals that actually appointed PSWs in those days and it was very difficult to get a job as a PSW. On one occasion the whole course applied for one position. Can I just ask you, as you've left the Mental Health course and gone to your first job: how easy was it for you to find that job?

M.B. I was lucky because I was a good student. While I was at the Maudsley, which was my second placement, word came round in about the month of June, that there was a vacancy. It was a very sad thing that happened but people took the very first job they were offered just to get one, then found it very difficult or not to their taste, and then spent a lot of time trying to get out of it. Now if you were lucky enough to get out, there was no-one else to take the job because the next lot of students hadn't been 'baked', so to speak. You see, we all came out of the oven at the same time. You either got a job then, or you didn't.

During your next year, you either got absorbed in a job or, because of occasional marriage or death, you went out of this sort of work altogether. So I got this job in June to start in October.

A.C. Did this happen in your year?

M.B. Yes. It meant the first person, the person before me at West Park left after about ten months (as the one before had left after a few months, the one before her ditto, and always there were gaps till the end of the year was up and more students were ready), they couldn't get anyone trained the previous year. The ex-students couldn't wait that long. There was no Social Security and they wouldn't be eligible for Relief, which was fifteen shillings a week for a single person. That meant they would have gone back to whatever kind of thing they had done before, or whatever came along. But the advertisement for this one had come through to the course and we were all invited to apply if we wanted to work in Adult Work, as it was known, not going into a mental hospital.

None of us realised that a mental hospital was an entirely different thing from the Maudsley. We had been taken round Long Grove one afternoon, another of the Epsom hospitals. **[21]** Why didn't anyone think it odd that we didn't meet Miss Godfrey, the PSW? She may have been visiting in London but she could equally possibly be there and know nothing of our visit. The Maudsley took only voluntary patients. It was new, progressive and had four outlying clinics in different parts of London in which we did some of our practical work, and one saw a recognised PSW role there. I wouldn't for the world give the impression that all was completely rosy there. It just seemed so, to us exiles in the outer darkness.

To revert to my first job, it meant that during the months when they were without a PSW, whatever she had done either lapsed or was done by the office. Everyone thought I was lucky to get the job because it was a job. I was envied because it was terrible disgrace to be unemployed. After two days I wondered if I could stick it for six months. Would it be honourable to leave then? I decided no, I couldn't stick it for six months. One of the others had only stayed four months, so perhaps four months would do. I stayed for four years!

A.C. What was so awful about it?

MB I can't think now why I wasn't alerted before I even went. I thought it a very wise idea to get in touch with my predecessor, Stella Waldron, before she left. She decided it would be a good idea if she showed me round the hospital, so we arranged that I would go one Saturday and she would bring a picnic, which we could have in the grounds. Saturday isn't a typical day in a hospital, so we didn't really meet anyone but we talked. I certainly thought she was very modest about her own achievements. But it was a job, and everybody who had been responsible for me during the year seemed quite pleased about it. When I was leaving she told me that the Physician Superintendent had been glad that I was visiting because he would like me to be informed informally and that I would find it a good idea to bring my own lunch and eat in my own office.

The hospital was divided into messes: clerks', nurses', doctors', carpenters', about ten messes in all, and you sat with your professional or craft fellows and a pecking

order was maintained within each group. PSWs had been graded to go to the Administrative Sisters' mess, except that the administrative sisters refused to have the cuckoo in the nest and although Doctor Roberts said that he was prepared to insist if I, unlike Miss Waldron, insisted on sitting where I was not wanted, he really couldn't advise it. I just accepted it. "Oh well," I thought, "it's an odd business but I've never met an administrative sister and I don't think being with one will help my job."

I just didn't know what ostracism was. I had no idea that I had been spoilt because I was good at my job, good as a student and previously had nothing to do with any kind of hierarchy. I'd always been paid by bargaining with my boss and knew by this, if no other way, that I was valued pretty highly. The idea of being disliked enough not to be allowed to eat with people before I had even appeared, or the idea of different rooms to eat in with your own occupational group, was all so odd that I truly didn't take it in. I found it so humiliating that I didn't tell anyone.

However, it had its advantages, for I discovered there were three other Ishmaels with no proper place within the tribal set-up: the occupational therapist, the physiotherapist and the medical superintendent's clerk, who, having once asked to be referred to as a secretary, was ever more called the Mrs's W.C. The occupational therapist was a doctor's widow and very scornful of everyone. She had a car and went into town one-and-a-half miles away for lunch. The other two came into my office and this was very nice as the Mrs's secretary, i.e. the woman clerk, could have made my job impossible if she hadn't got on with me.

As far as the work was concerned, I suppose it was partly the PSWs themselves who came, set up a department and indented for equipment. Talking of setting up a department connotes something rather grand and foreign to people who had never heard of a psychiatric social worker before, including clerks, nurses and even some doctors.

So although you were frozen out by the fact that no-one gave you anything to do, or discussed anything, or even wanted you there, when you left it was annoying for them to have made arrangements at your own request, so that you could do what you thought you wanted to do while you were there. This had happened three times! I was the fourth and I was told, "What is the good of getting you such-and-such, because you won’t stay? It's not worth it to us!"

A.C. What was it they were doing that was putting people off?

M.B. I don't think I can enumerate a lot of petty annoyances. You meet this whole atmosphere in an ancient, in-bred institution, with everyone's duty and responsibility rigidly charted, and everyone had trained for years for this one kind of existence. Then these strange women came in one at a time for a few months, talking as if they knew about mental illness because they'd been to a child guidance clinic. This kind of isolation departed as the war gradually brought other people in. Just having women clerks to handle food coupons brought some fresh air, but they had an understandable function. Still, I think this side of things got better in about two years. Yet the inability to get it accepted on the wards, so that one might have a way of contributing to the patients' or their families' welfare, was never really accepted at

West Park. All right, if you can, then do it, but the idea of collaborating, sharing information or opinions and not just accepting or receiving orders, didn't get over.

The central problem was the same for all hospitals belonging to the London County Council (LCC) and in many others (although some things would be easier or harder in different places), personalities would respond differently. But in 1942 it was so bad, perhaps not so bad, but settling into chronicity in spite of us having stayed put for a year or two, that a few of us had began to meet at each other's flats and have our own little meetings to talk about these frustrations. Some, according to their own accounts, had been accepted by their hospitals. Everything was marvellous and they were the doctor's right hand man. They didn't stay in the job any longer than the rest and we all recognised the psychological need to feel accepted and those of who grumbled, only did so among ourselves. Our real grumble was not that we were not liked as a 'profession' but that we had no chance to do what we had trained to do and could see the needs unmet.

A.C. So there was a group of you who got together?

M.B. We decided to speak to Clement Brown and tell her something about the conditions. In a way, the training had taught us that most things were one's own fault, or rather, that your personality determined your outlook and experience. If you were somewhere where you weren't getting on, it was due to yourself in some way. No, it wasn't the training but the mass of reading we did of books with this kind of slant. Your relationships were wrong. Having done the course, we must be able to manage. This is what we told ourselves that we would be told.

By now there was no need to stay in the hospitals. Jobs were opening up and not only in mental health. We weren't thinking of ourselves having no job if we left but of the needs having no chance of being met. So we spoke to Clement Brown, which was difficult. None of the tutors had ever actually worked in a mental hospital and really knew nothing about it. Clement suggested that we should each send her a report and try to say what the difficulties were and she would take it to the Mental Health Course Training Committee, who might decide that something could be done from their end. So we did this and I, thinking it's not much good saying this-and-that and that anyone can say, "Well, you must be the wrong person in the job" (although I had a shrewd suspicion that this was not the fact). We needed an influential sponsor, so I wrote to the three people who had been in West Park Hospital before and told them what we were doing. I didn't paint my own experiences black or invite that kind of thing, but asked if they would write me something that I could say, so the first felt this and the second that, and here I am, the fourth and this is what I feel.

And they did and I did and we know the reports arrived somewhere but somehow we never even discussed this flop among ourselves. We simply heard nothing about it. I think the war had taken a turn, which meant that an attitude grew that one mustn't grumble about little things not connected with the war and this slid into the assumption that we were complaining about war conditions. But these were conditions dating from 1935, and were not material ones. However, I always kept my copy of this appeal to my trainers, and I never saw the ones from the other hospitals. I've had it copied for you. It is an informal report of PSW work undertaken at West Park since the first part-time worker and it is dated 1941. (I had been there two-and-

a-half years by then). It was marked 'Confidential. For the use of the Association of PSWs Only'.

Oh, seeing that makes me think we approached Clement not as connected with the training but as Chairman of the APSW. I can't remember. But the document was written in 1941 and is much more useful than my memories now. It's not so much memories, as the authentic squeak of the toad beneath the harrow. You couldn't say I let my hair down exactly, because by then I was sceptical enough not to be absolutely dead sure that the thing wouldn't get back to my own hospital. But you can still read between the lines. If you would like to have that, it will save my telling you about the hospital.

A.C. Thank you, I appreciate this very much. Can you summarise in a couple of sentences what was wrong?

M.B. No, it cannot be summarised in a couple of sentences, and I should distrust my own or anyone else's summary.

Let me tell you something that isn't on that report. You ought to spend some time at the GLC archives, **[24]** which I did when I was writing something. I went to find out the pre-history because there were so many stories about the course being all to do with psychoanalysis and all that. There was a lovely bit in the archives connected with people going over to America to study work in the early Child Guidance Clinic. Someone who had made this visit already was asked by the Committee if it was to do with Freud and that sort of thing, and she assured them, "No, the Child Guidance Clinic we shall set up here is not like that at all, we promise you." It's interesting compared with what one hears now, but the archives also give an idea of the way we were 'sold' to the mental hospital. The power behind the hospitals was the Asylums Committee of the (London) County Council and full meetings were held at County Hall. **[25]** A group of members would come to the hospitals to discharge various functions.

This Committee was persuaded by one of the voluntary bodies interested in mental health (before the National Association of Mental Health) to employ PSWs as an experiment, the salary being paid for in the first year by this association, of which Miss Fox **[26]** was Secretary. As would be common practice then, the relevant extract from the Minutes would be sent to the medical superintendent whose hospital was chosen. No doubt the first person went to the hospital where it was known that the superintendent was keen on the experiment (and there were some). But some medical superintendents were simply outraged, although I can show you no written proof of this, by simply being told that 'the Council has appointed a PSW [name given] who will come and take up her duties on [a certain date]'. When you think of the power of the medical superintendent over the thousands of people in his hospital, you can hardly expect the flags out for us, although some liked the idea and some just liked having anybody different from the rest.

On the other hand, we were the only people who did not wear any kind of uniform. The clerical staff didn't go about on wards in those days. The nurses were got cheap from Ireland in the 1930s. The clerks would start at sixteen and go on until sixty. They might transfer to one of the hospitals on the 'promotion zigzag' but all they

knew as a working area would be the hospital and they would know the hospital, the customs, the hierarchy and the minutest detail of custom.

Then came these people who nobody had heard of. They said, "They're trained and qualified and don't know a thing about the actual day-to-day ways of the hospital." I didn't know even enough to know this. I must have made an awful lot of blunders then. In those days, the doctors (men and women), always got up when the medical superintendent came into the room, and anybody (nurses, anybody), when a doctor went by, went to the sides of the corridor, and the doctors did this to the medical superintendent. But the nurses did it to all the doctors and everyone did it to the matron, except the medical superintendent himself, I think. I don't know what I would have done if I had ever actually been told about this instead of just noticing it but luckily I didn't know, so I'd go about just as I'd go about anywhere else.

Other extraordinary things happened but that would take three hours!

A.C. Tell me some extraordinary things.

M.B. No-one ever asked me for any sort of advice; nobody really ever asked me to do any work, but we took histories if they hadn't come from the observation ward. You just saw there was no history in the ward notes, took the name and address of the appropriate relative, did the history by visiting, and placed the top-copy in the ward notes and nothing of any sort was ever said. It used to remind me of a leprechaun cleaning the house while the family slept.

Then I did these on-trial visits during the month that the person was on-trial and afterwards, such after-care as I could. A list of names was left with the nurse in the reception ward. I was told by the superintendent's clerk (off her own bat) that if the visit was too far or I didn't want to do it or it had not been given time, that it would be arranged for the Mental After Care Association **[27]** to take the patient for the on-trial period straight from hospital into one of their homes.

There was no licensing of homes then, and they would take anybody at a moment's notice if the hospital asked. They got a grant for maintenance from the hospital, not from the local authority. I have known a matron of a home asked to take someone the same day, give the patient her bed and sleep on the couch. You couldn't do it now; the numbers would be wrong; you'd be overcrowded. It would be a large house with two nurses having retired, who would get a little money doing it. They would find it easy after having being mental hospital nurses. The patients would benefit, as they might get work after coming-off certificate and stay on there as private, paying lodgers. But the idea of people giving up their beds to make room!

Another thing the hospitals would do if the PSW left or was off sick or couldn't get to a relative's home in time to get in a report, was to say, "Oh, he can stay another month." It made it difficult on one's conscience, it felt wrong and made one feel rather responsible for that sort of thing.

It meant the hours were ridiculous. Sometimes, you only had two days in which to make appointments and get reports on perhaps twelve patients whose relatives might or might not go out to work. The alternative would be to ask for the names for possible trial to be listed early, so that you could arrange visits sensibly. Then, if

anyone recovered between the time the list was made out and the committee meeting, they might not be considered until the next month.

A.C. The committee?

M.B. The Discharging Committee, who sat to see the patient. The medical superintendent had to recommend that they should have this when on-trial.

A.C. Who was the committee?

M.B. The committee came from (the LCC) County Hall. They were called the Asylums Committee. Difficult to explain, if you don't know.

A.C. What sort of people sat on it?

M.B. A grocer – or whoever you would get on a local authority committee! Just like the Housing Committee, this was the Asylum Committee. They came down on a certain day, had lunch and had names put forward by the medical superintendent. I mean it was a rubber stamp. If the medical supervisor thought someone should be recommended, they could have nothing against it. The only thing was, if they were S79 applications from a relative and there might be a charge on the rates, we went back to in the 1601 Act. **[28]** The on-trial, 'likely-to-be-discharged-as-recovered patient' was under another section of the 1890 Act. The idea of being 'fit-to-be-home' but still 'under certificate' wasn't such a bad idea as it can be made to sound now. It was protected time for them. They had a grant from the hospital for their keep. It gave the social worker a chance to do something, perhaps about a job, perhaps to explain something about the whole set-up, which often helped to take away the bitterness of having been certified. All trials must include some chance of failure and there was always the danger that the patient would break down again during the month (there were no maintenance drugs) and you had to cope with that. I did this sort of thing for two years and no-one of the medical staff ever spoke to me about my work. I put in my on-trial reports and I did actually ask the medical superintendent once, if I might be present at a Committee meeting, (as I knew some did this at different hospitals) because I found some of the patients were frightened about it (the relatives just as much) when they were summoned to come.

I can't tell you the inhuman letters they wrote. No-one inured to the system saw them as such regarding the name of the patient on the hospital books, listed not as 'reference' but 'number of patient', although no doubt it was done to serve as an easy reference. Then there were about six lines saying something like, "In pursuance' of a section of this Act, your son will be examined by the Discharging Committee with a view to being placed on-trial and you are required to present yourself… etc." I can't remember the exact words. I kept some copies of these form-letters for years but they must be available somewhere. People were terrified that any word they said might be the watershed word to upset an official and send events down the wrong side. I didn't know what did happen.

This is what I meant by feeling I hadn't the practical training. I ought to have been able to say from training experience, what it was like and reassure them. I heard an awful lot about giving reassurance in the training but I am not one who can use reassuring words when I am ignorant of the circumstances myself. It seemed

dishonest to me. So I asked the superintendent and he drew himself up. Whether this was because I dared to speak or because of what I dared to ask, I don't know. He said that if his staff were capable of giving the information, he was capable of conveying it to the committee. When I tried feebly to say I knew this but that the people most concerned were a little nervous, that too was "his job and he was perfectly capable of putting people at their ease". There wasn't really anything in that mental hospital about which I could say, "this is my job" because everyone felt they were capable of doing any social work. I'll explain why not, if you like.

A.C. So the notion of there actually being a conflict of views, say between you and the doctor, was out of it?

M.B. Quite out of it!

A.C. There was no arena for discussion?

M.B. Nothing like that then but gradually I pieced things together from what I heard each month. The patients and relatives told me, not realising that I was learning. I would say when I visited them, "I wasn't there myself: how did you find the Committee?" They assumed I was busy doing something else. Eventually, I formed quite a good idea and could honestly have reassured the next batch because of the pictures I had formed from the graphic descriptions of those who had gone before. What is so like life, years after, when I was in another hospital and had learned to keep myself to myself and not draw attention to myself, I was told in a very reproachful way that it was a pity that I couldn't find time to go to the Committee myself when one of my own patients was to be considered.

A.C. You can't win, can you?!

M.B. I did attend after that. The difficulty of describing things with any attempt at brevity is that you may get the impression that it was always bad and bad in the same way. Things changed in some ways, advanced here and slipped back there.

One day in about 1942, I was told by the superintendent's clerk that Doctor X was inaugurating doctors' case-conferences, starting at eleven o'clock that morning and required me to be there. Between that time and eleven o'clock, three nurses told me about this and that they had heard I was to be there and added, "He hasn't invited the Matron!" This was in the year I left.

Another odd thing happened one day: I was told on arrival, again by this very nice 'not-to-be-called-secretary' that a very, very high-up civil servant, who was Sir Somebody, had written to come and see the medical superintendent, who had had to go away. Even I had heard of him. He was the uncle of one of the patients who had been there about six years. Before going, the medical superintendent had arranged that I should see Sir and that I should see him in his office, which I had only been in twice before. (You walked several miles up to a very big desk!) My thoughts were, "Well, the other doctors will kill me!" (You can't go straight down from the superintendent's office to the PSWs.) But it seemed that it had been arranged that the next-in-command should have a few words with Sir on his arrival and then someone would notify me and I would conduct this interview but I was never told why nor what. It was so crazy.

A.C. And you still don't know to this day?

M.B. Oh yes I do! The medical superintendent's deputy came into my office before the man arrived and showed me the letter in which Sir said he wanted to know how his nephew was. He thought there were things in the past that might help the doctors and he would like to come down to talk about it on the strength that nobody else could take a history but me, it seemed. That was how it was arranged. I went and he was a very nice, worried man who just felt, I think, that his relatives were worried. They had communicated their worry to him and he'd said he would come and try to get the hospital to understand the position at home. It was like taking any history really, which was never just taking a history. That was the kind of thing. I seemed to be the last person they should have asked, judging by past experience from their point of view. I suppose that in the two years in which they had read histories and reports which I had written in the full consciousness, that this was the only way I had of indicating (oh so unassumingly!) what could help or distress members of patients' families, or hinder or contribute to the patients' comfort of mind, and it must have begun to get through.

I think in *Staying the Course* [an article in the *British Journal of Psychiatric Social Work* in which MB reviews her long experience as a PSW] I do refer somewhere to the fact that after six months, the attitude of positive hostility changed because I had a personality thrust upon me. But this is a very long story, if you want it.

A.C. Yes, please.

M.B. It does give an idea of the hospital of that day. When I got my famous list of people who might go up to Committee, then it was up to me (although probably I'd never seen the patient before) to arrange my visit to the relatives to prepare them etcetera. There was no question of picking up the phone and saying, "Can I see Mrs So-and-So?" and have a nurse bring her over, as would be done for a dentist or a clerk. I wasn't big enough for that. Besides, by then I had found it was better to go and see them: I would go to the ward and make sure the patient understood they were going up before the Committee. What I would do was to check the address that they would be going to, ask if they knew what kind of time their relative was likely to be at home, and how best to get there. Really, it was a way just to get to know them. I could have found this out by other ways. I got to know them because of visits afterwards and was able to tell the relatives that I did know a bit about them, as a way to make their acquaintance.

I went on Thursday. My days were Mondays and Thursdays and I scurried around London on Tuesdays, Wednesdays, Fridays and Saturdays and also on Sundays, if necessary.

I should break off here to explain about hours. At the hospital it was assumed that I never did any work except when I was there. Who would, if there was nobody to know where I was? On the list of Conditions of Service given me on my appointment, the hours were 'according to the requirements of the Service'. Not a figure, not a precise figure. In the 1930’s, people worked all hours.

Once, the people I was to visit wouldn't be home until nine at night and they lived a two-hour journey from my home. This was where the patient was going to stay; on

her own until 9 p.m! So it was necessary to go to see what arrangements could be made while the people were out of the house.

At that time, the reception ward was the place in the mental hospital where you not only received patients. (After all, the certificate was embodied in a Reception Order.) If they were likely to get better, that is, if there was a chance that they were not going to be there for years and years, they remained there. So I did most of my work in there because there were people, quite often the people I was going to visit on-trial, who would still have remained in the reception ward.

So you get to know these particular male and female wards better perhaps than many of the other wards, where the patients had been for years and years. The nurses here were kind. One saw it in their attitude to the patients. But they were not nice or helpful to me and they really didn't want me about.

I sat and talked to this particular patient and noticed that the day room seemed fuller than usual. They were all coming in and sitting down, ushered in by nurses if they seemed to wander. The place looked more and more full. Chairs were coming in and being placed round the walls. It began to look like a meeting. Anyway, I still wanted certain particulars from the patient and then was going to get out in a hurry in a minute or so. The patient was a bit slow and I wouldn't hurry her. Then I looked up and saw the Church of England Minister had come.

Nobody had ever introduced me to anyone. I had to find out who people were. Some knew who I was. The minister mightn't know me and I didn't wear any form of uniform. Then I saw why there was such a crowd of people, all sitting quietly around the walls. The minister was going from one to another, tapping their shoulders and saying something. I thought, "Please hurry, good lady, so I can clear out." He was getting nearer and nearer and I thought, "I shall have to get up and go." But I also saw that he had come round to my side of the circle and would see any movement of mine in that unnatural silence. To get up and go seemed all wrong. The only way in which I could do that, yet prevent his saying, "Sit down, my dear, I'm coming to you" was to show my keys obviously in my hands. This is sign language for to say, "I'm staff; you can't do this to me." The keys were so huge they wore out my pockets.

He came nearer; I saw him come closer and closer. I started to write my next question but my patient didn't respond to me at all. I thought the only thing is to noisily pick up my keys and get out, but I couldn’t. I then realised that if it were a question of doing that, or being mistaken for a patient, I don't know anything about professionalism, so I just sat. The minister was two chairs away. He came to the next person and patted her on the head and said, "Come to church on Sunday." Then he came to me, patted me on the head and said, "Come to church on Sunday." He also said it to the next person. All became a murmur again. As he turned round to the next set of chairs, I did get up and walk out and it was only later that I remembered that he wanted me and any patient with bowed head to come to church on Sunday because it was Easter.

I didn't go to the hospital again until Thursday. When I went into the nurse's office where all the records were kept, she seemed ever so much more pleasant and invited me in to have a cup of tea. A young nurse came in and on seeing me, said,

"Oh, I wish I had been there on Thursday!" I stared at her, as she seemed to be addressing me as if I was staff and someone you could talk to. The senior charge nurse said, "Anybody who can make the whole ward burst out laughing all at once at the same thing, can have anything she likes!"

And from then on, I did have everything I liked on her ward. All I'd wanted was to have them tell me about the patients in an informal way. Their stiffness was probably due to the fear I would use my knowledge in such a way that they would feel betrayed. Nobody ever mentioned it to me again but evidently the whole hospital got the story, though what sort of story, I've no idea. I think it was a bit of a laugh at the parson. It was certainly a laugh at me but I don't know if it was something to do with my face or what it was. So funny. When people talk about professionalism…I know I've done some unprofessional things.

But the incident did make a difference. I could do anything, or certainly an enormous amount more after that. People would tell me things, that I could use to work on behalf of the families. But as I indicated, there in the 1941 grumble I've given you, after this episode, when people let themselves get to know me, they would 'gossip' with me about anything but if I looked about or asked another question, as though this was something I could help in, they would draw away. That they didn't want. How much of the better relationship was due to the fact that they hadn't expected me to laugh, I don't know, but I hadn't laughed. It was the patients who laughed.

A.C. So are we talking about West Park Hospital?

M.B. The Easter affair was at West Park. When I took the history of the eminent family, there was still this sense of complete isolation but without the hostility from the nurses et al. But when you think that although some of staff might not have spent all their time in that one hospital, they had spent all their working life in a mental hospital, and I relied on them absolutely. I do remember going and complaining to Janet Jackson that life as a PSW wasn't quite what I thought it might be and that there didn't seem to be any point in what I was doing. She reminded me we were pioneers. I hadn't thought of myself as a pioneer, nor much liked it. If you are a pioneer, you can't have a structured, clear position, but that's not the same as being unrecognised as a pioneer or even existing among thousand, who all had their proper places.

Then the superintendent of Horton asked the West park superintendent if I could do some work in his Malaria Therapy and Research Centre, later renamed the Mott Clinic, **[29]** which I'll have to explain later.

Horton was one of the four two-thousand-bed hospitals in Epsom. Since 1929, all General Paralysis of the Insane (GPI) patients in the London area were sent there and eventually, patients were sent from mental hospitals all over England. This centre was housed in a villa in the grounds, not in the main building. The Malaria Research Unit was nothing to do with the National Health. The Malaria Therapy Unit, staffed by the Health Service, used the same patients both to treat GPI by malaria and by research into malaria, which had become more and more important during the war.

When war came, the whole of the rest of Horton was evacuated and was taken over as part of King's College Hospital, a teaching and general hospital and as an air-raid casualty hospital. It was organised so as to be always prepared for waves of seriously-wounded patients being flown in from the battle areas' Casualty Clearing Stations whenever the Allied Offensive should start.

My colleague there, worked first in 1935, as I did at West Park, then more intensively at the thirty-bed MTRC, which was all that was left on evacuation of patients in 1939. 'Kings' brought its own staff, absorbing those nurses who didn't go with the evacuated patients, and its own surgeons, specialists and almoners.

In 1942, Anne Le Mesurier **[30]**, the PSW, went off to be an officer in the Wrens but there was no likelihood of getting a PSW to take her place. If anyone would apply for such a revolting job as working all the time with general paralytics of the insane, the LCC certainly wouldn't pay a whole-time salary.

Just then, West Park had an outbreak of dysentery and there were no admissions made for a time. My superintendent asked me if I would put in a few visits to Horton during my days in London. This didn't just mean the time doing the visit but I also had to go to Horton from West Park to get particulars of what was wanted. Because of the whole nature of the disease, plus the need for both secrecy and for getting contacts tested, I had to be given necessary information other than I'd learned on the course. While I saw mistakes made here, which were terribly distressing to the people concerned, one had to consider medical confidentiality, potential libel suits, etcetera. One had to be trusted and one had to be able to ask for information.

I remember my first case. I stepped off the bus and two warring families sprang upon me. There was no physical assault but an attempt was made for me to hear both stories at the same time, there in the middle of the street.

Eventually, I worked there singlehandedly but I was absorbed in a team, which, with me, always included patients and relatives. It was all loosely structured, apparently quite informal, with no conferences and no training. Ostracism no longer existed. The hospital was against me but the General Teaching Hospital was against 'the place in the grounds' and too remote to matter.

I retired in 1959. Malaria was no longer the treatment for GPI, so it was not necessary to have a special place for treatment. I was very ready to go then, and being an 'asylum officer' in regard to my pension, I could have gone at the age of fifty-five. I haven't any more to say on that point except that since training, I have never been anything status-wise except a PSW, sometimes on the basic grade, sometimes with a responsibility allowance, according to other people's vagaries, and always in traditional mental hospitals.

A.C. Going back to the course, what is the most important idea and have any of the ideas emanating from your training or reading, helped you in your practice?

M.B. Yes, there came a time when PSWs themselves began either to want to treat directly, those people with emotional troubles or who were mentally disturbed or something, or they said they were being asked to do this. This is very difficult. We all know there is no clear dividing-line in the centre. Yet there is really a big difference

between the sort of person and the problems of the family of the sort of person who has never been treated for a psychotic illness or even appeared to be outside of a wide range of normality, compared with those people who really aren't recognisably themselves in any way.

I mean, in our ward once, we had two kings of England! I bet it was the only place where two kings did not quarrel. They didn't notice each other. They were so mad, I mean mad. When we had a history of another patient coming in and found he was a king too, the nurses did go to the trouble of putting them in beds as far away from each other as possible. It didn't make the slightest difference. They didn't recognise each other.

This is what I mean when I say 'mental' illness, whereas nowadays so many 'trained' people would say 'mental illness' because someone has feelings of inadequacy. When has someone not had feelings of inadequacy at some time?

It has always been very difficult when we (that is, my colleagues and I) try to explain our work in the hundred-year-old mental hospitals. We were (and perhaps some still are) concerned with the families of grossly ill mental patients and their partial recovery. Partial in varying degrees, as in sometimes not acceptable to the person himself, through treatment in hospital, through the perilous transition to their version of normal, and through the vicissitudes afterwards. I worked very much as I think we did in a Child Guidance Clinic, in that I worked primarily with the person who was not the one who came to the doctor's or therapist's attention because of their own symptoms, but with the person who was the most important person in the patient's background. This way, I never had a feeling that I was doing anything therapeutic in the way it should be done by a doctor or psychiatrist. I needed all the knowledge of psychiatric matters that I had learned and could learn, not to practice myself but in order that what I did in my own speciality, was as good as I could make it because of my knowledge of psychiatry or of the law, housing provisions, new bus-route between a patient's home and work, and so on.

I think if I had been a different person and had been thrown into a job at West Park, I might have managed without the Mental Health course but I wasn't the sort of person who would accept a job without at least as much training as one could get; so it doesn't really arise.

A.C. You were still a member of the Association in 1956 weren't you? So you remember they put out a publication called *The Boundaries of Case Work*? **[31]** There is a big dispute and discussion between Betty Lloyd Davies on the one hand and (I can't remember who argued the other) about whether case work deals with transferences in the social worker and client relationship. There's a discussion called, *Is Case Work the Same Thing As Psychotherapy*? Do you remember those papers?

M.B. I think I remember reading them when I did my 'Staying the Course' thing, as I read and read until I was sick to death, but I'm eighty this year and can't honestly remember with clarity, although I might have done.

What I will say, is that I have various papers of Margaret Ashdown's and among them, she mentions this thing about transferences and again says this is something that would (and does) happen in the ordinary course of living between every sort of

person. Transference happens. I would say the PSW learns to perceive it and to bring it into her whole knowledge of the entire situation. You don't have to call it anything or even to refer to it or think, "Am I doing anything about it?" because what you do, is something towards the whole situation you find yourself in. Beware the effects of piecemeal tinkering but then you don't even imagine them unless you've had at least a little experience in after-care, which checks both the patient's progress and the effects of your own work.

I have lived through so many fashions, that I don't know the difference between fashion and theory now but if you ask me where the ideas came from, then I would have to say that in the 1940's and 1950's, nearly all came from America. There was a time when the COS here had its peak in about the 1890s and then led America but I think all of us could still get a great deal from Mary Richmond **[32]** making the necessary adaptations for ourselves. Then our people went over to America and occasionally, some would come over here, and all sorts of ideas came. Really, I had no opinion about them. It all seemed so bizarre. I could only feel it applied in some cases but not in mine. American books seem to deal with agencies whose original, justifying function was to give a personal social service but a British mental hospital had quite different origins, justifications, aims, traditions, practices, strengths and weaknesses. None of the pre-war students trained in a social service agency. If you ask me about these things, it's like asking Noah about building of the temple. People got terribly hot about a cup of tea.

A.C. I remember that one!

M.B. I'll tell you a story about a cup of tea. It was in the war. I ought to tell you that I seem to remember so many war things that made these kinds of ideas seem odd, not so much inappropriate as quite irrelevant. I did all my visiting (so much visiting!) during the war under war conditions, that some of the ideas people came out with seemed so odd compared with my work and conditions of work.

One story first about on-trial visits during the war. I've explained earlier that patients on certificate might be considered more likely to consolidate their improvement if they weren't taken off certificate until they had a period in the conditions to which they were expected to return to indefinitely and that I found out first where they would stay, who with etcetera. Then I did what I could during my on-trial visits. It allowed the patient to be brought back, if he relapsed but with no formality, no magistrate, observation or re-certification. Often, when asking for an address during the war, I would be told it and also that one or other relative would go to that address every day. "So if you write, we will get the letter but of course, we spend all the rest of our time in the tube, sheltering from the bombing." They would tell me which station and I would do my pre-trial visit to find out what the domestic situation was, and then make my three on-trial visits there.

I would arrange to go by tube and on the train, I'd come into the particular platform where they had their bunks, and just stand there until somebody claimed me. They would call or wave and come and get me. I would do my visit, all crowded around with everyone else. You saw quite a different side of everybody because their neighbours would be there and everybody would know I was coming and very often

they would all envy the patient. "Wish I could go and spend a month out there in your place, getting all your meals and rations and be safe with no air-raids."

I didn't have long discussions with the clinic staff about my role as 'hospital representative to the public', the expert in changing attitudes towards mental hospitals. I just knew that all this entered into the situation. Things were rather different from what some people may mean by 'home visiting', but I was concerned with the patient's home environment and I went wherever that was. When people talk about 'should you or shouldn't you drink tea', it seems as odd to me as talking about clients. Who, at any time, was my client?

What I was going to say was that we had a male patient having treatment. His wife had been tested by her own GP, when it was discovered what was wrong and that her blood was positive. She was advised to have a lumber puncture and this was also positive. These results were sent to the clinic. We didn't know that she knew she was positive. In our experience, 'doctors don't tell their wives'. We thought it was a good idea for me to go and see her, rather than anyone write to her, and to tell her she would need treatment that we could give her, and for me to talk the whole thing out with her. I wrote to say I would come at a certain time and it was pretty miserable because she lived right in the north of London and I lived right in the south and then the air-raids always came at six o'clock. This was alright, unless you happened to be going say, between Charing Cross and Waterloo when you got caught, because it was impossible to get across the river in the tube, so you might be stuck all night, which wasn't much fun. At the back of my mind was the thought that it would be nicer if I was on the right side of the river by six o'clock. However, I set off.

She was a very forbidding sort of person; a very cold, very big woman, rather snappy. She invited me in and we went into the little sitting room, which was cold, smelly and unused. I don't know how we got on at all. She was very bitter, asking (naturally enough) why she should have to go to a mental hospital when there was nothing mentally wrong with her. All together, we didn't seem to be getting very far. I asked if she would like to think it over and if I should come to see her again. She was quite sticky initially but then she agreed to think it over and perhaps would see me again or write to the hospital. I thought, "There isn't any more I can do and she knows the facts as well as I do." However, I couldn't have known this without coming to visit her.

I made a move to go when she said, "Will you stay and have a cup of tea?" I thought I could get away without this, as her attitude before had been so different. I very seldom left anywhere without a cup but this time I was hoping not to. I don't much like tea and the tea that people gave you was on the principle of 'the warmer the welcome, the stronger the tea'. Usually I took tea just because it seemed the right thing to do.

Just as I was wondering if I could say 'no', I remembered (I've always had a visual memory) that as she had shown me into this room, I'd had a glimpse in the kitchen of a tray with cups on it. This was at the worst part of the war, when nobody had cups and saucers that matched. Either they had all gone by then or they were locked away for the duration and you used mugs or odd cups. These were the sort of cups and saucers you saw before the war, meaning she had prepared beforehand. I said

'yes' and she brought the tea in and, not as most people do, offer me either cake or biscuits (although once I had bread and butter pudding) but offered me tarts – obviously-home-made jam-tarts, and this was in the war!

She poured my tea, gave me a tart and I sipped the tea. She did nothing. I remember she was so tense, sitting there, doing nothing, waiting. The tea was too hot so, not to waste time, when I put it down, I took up a tart and bit into it and… she flopped down among her tea and tarts and burst into tears and sobbed and sobbed! I went on eating the tart. I didn't know what better to do.

Then she told me that after she had had the blood test, before she knew the result of the other test, she decided that she was infectious and that she mustn't speak to anyone or they would catch VD through her. She had been indoors for six days and wouldn't speak to the neighbour, not even over the wall, because she wasn't sure she wouldn't infect her that way. She couldn't believe a word anybody said, because the GP had said, "We'll give you a blood test and you'll find you are alright." But she wasn't alright and then he had said, "We'll give you a lumbar puncture and you'll find you're alright." But she wasn't. This is what made my visit not seem worthwhile, because we didn't know she had been told all this already, and so she couldn't believe anybody.

Then the hospital sent someone (me) to see her and she wouldn't believe a word I said. She asked me if she was infectious to other people and she wouldn't believe a word I said but she was sure the hospital wouldn't send me if she really were infectious, from the point-of-view of talking to other people, so she could trust that I would not have come had she been infectious, as she believed she was. But she had set a trap. Cake she might have bought, she wouldn't have handled but with tarts, she would have had to use her hands, and she made the tarts. She had trapped me.

I often heard the APSW talking about the client controlling the interview, having the interview the way they wanted it. This was manipulating a PSW. I walked into the client's trap and of course, it was the best thing I could do or that could possibly have happened to her. I ate her tarts, and she said she was alright now and cried and cried and was wonderful after that, as she felt so much better.

One thing I always did at this time (nothing like structure and technique!), which I did for my own benefit during the war, was I always asked as I went out, "Which do you think is the best way to start to get to…?" because with the bombing, the situation changed all the time. In this case, I did the same thing as I went out, and she said, "I'll come with you to…" Obviously, that was the right thing for her to do, especially as she added, "…then I can call on next door as I come back." So, I couldn’t enter into an argument about things like cups of tea in theory, because I don't know them in theory. It may be a very bad thing to do in some circumstances but you have to wipe out the circumstances when you theorise.

A.C. Fascinating!

M.B. I can't tell this sort of thing quickly and concisely without improvising and perhaps misunderstanding.

A.C. I don't want you to. It's better the way you are telling it. At the time I started in social work, there was definitely a general feeling that to be directive in any way whatsoever, was to be anti-case work and in conflict with the case work values. That was shifting a bit by the time I did my training. But I started work in 1957 and that sort of permissive, non-directive, 'you can do what you like' and 'say what you like', was definitely the feeling. Can you remember another anecdote about being non-directive? .

M.B. Yes, I do have a story. I'll leave it to you to see if you think it applies.

For a time (and this I won't discuss any more), I was a tutor at St Ebbas, just for a year, to help out. A tutor in the Mental Health course at LSE left this field unexpectedly, just as Kay McDougall (Interviewee no 14) would have gone to set up practical training for students' placements. Instead, Kay went to the LSE. Things were so advanced at St Ebba's, **[21]** that they needed someone to fill in there, so I went, but certainly not under the best conditions for me. I didn't know the hospital and the students arrived three days after my first appearance, expecting I don't know what, as no-one told me.

Again, I believe you must know your place before you begin to have any sort of authority. I've always had a feeling you have to know a lot of things all around a particular thing you are talking about. If you are only dredging up from your bare knowledge, however specialised it is, it doesn't work to the same extent. You really are able to help much better when you have so much knowledge around the central issue, even to such small things as the difference between hospitals that were replicas of a proto-hospital on paper, and also the difference between the people who were holding the same statutory, rigidly-defined positions in two apparently, seemingly identical set-ups.

I did go and I got to know the wards and the people. And let's hope adequately enough! I went off with my students to the observation ward in London, where the psychiatrists from St Ebba's saw people with a view to deciding whether they should be offered VP treatment at St. Ebba's. They also saw discharged St Ebba's patients; a kind of maintenance measure.

Among the staff nurses at St Ebba's was one charge nurse who had been a sergeant major in the 1914-18 war. Almost anyone would have spotted that; he was the perfect stereotype. I can remember the social worker at St. Ebba's who, of course, knew the set-up and the people better than I did, thought that among the things we might have to explain to students exposed to mental hospital life, was that this man had quite a kind heart. He wasn't like he appeared to be. I knew it would send a shudder through the students to hear him barking at his patients, sergeant major like.

This particular day at the clinic, one of the people who had been a patient at St Ebba's, was being maintained by coming to see the same psychiatrist from St Ebba's. That day, he was relapsing and hearing voices and was fearful that he would respond to them. The psychiatrist said, "I think you ought to come back to us. What do you think?" He said he didn't want to but added reluctantly, "If you say so." She (the psychiatrist) said, "You must make up your own mind and I would advise it. If

you would like to wait and come back and see me next week…" He thought for a bit and said, "Could I go Cedar Ward?" The psychiatrist asked why. "Well, I'll be alright with Mr Williams because no voices will stand against him because he will tell them where to go!"

I think that's a lovely story about how you must never direct. He really was a complete sergeant major: his manner, his voice, and the way he talked to people. 'No voices will stand against Mr. Williams!'

A.C. Yes, that is a lovely story.

EDITORS' NOTES TO THE BREE INTERVIEW

1 **The Mental Health Diploma Course at the LSE**. This one year course was established in 1929 with financial aid from the Commonwealth Fund in the USA and this support continued until the1940's. However, as Professor John Stewart has established by researching the archives of both organisations, the relationship was a complex one and not without difficulties. The senior staff of the Commonwealth Fund had had strong views on how the course should be run – particularly in relation to the course content and the experience and qualifications of admitted students - while the LSE wished to maintain its independence. However, threats to withdraw funding were not carried through and the course became established .

For a considerable period this was the only course of its kind in the UK and hence carried considerable prestige. It formed a focus for the expansion of the profession of psychiatric social work from a very low base: in 1930 the newly formed Association of Psychiatric Social Workers had only 17 members. The curriculum included the different existing strands of psychiatric theory and practice; intra-family relationships; and disorders of childhood. Those qualifying went into, or returned to, a variety of work settings; child guidance, mental hospitals, local authorities and voluntary agencies. Over the years the influence of this course gradually spread.

For a fuller discussion see: Stewart, J. (2006). *Psychiatric Social Work in inter-war* **Britain:** *American ideas, American philanthropy*. Michael Quarterly. www.dnms.no ; and Noel Timms (1964). *Psychiatric Social Work in Great Britain: 1939-62***.**

2 **The London School of Economics and Political Science** (informally, the London School of Economics or **LSE**) was founded in 1895, the moving Fabian spirits being Beatrice and Sidney Webb, Graham Wallas and George Bernard Shaw. The initial finance came from a bequest of £20,000 from the estate of Henry Hunt Hutchinson, a lawyer and member of the Fabian Society. He left the money in trust to be put "towards advancing its [The Fabian Society's] objects in any way they [the trustees] deem advisable". The aim of

the School was the betterment of society through the study of social science subjects such as poverty and inequality.

The important role of the LSE in the development of social work education is referred to in several of the Cohen Interviews. The Charity Organisation Society (COS) sociology department - that had provided some theoretical training for social workers - was absorbed in 1912 into the LSE's new Department of Social Science and Administration. The range of courses later provided by the Department was described by David Donnison in 1975: "The Department was teaching about 300 students at this time (1956): about sixty were taking the Social Administration options in the second and third years of a course leading to an honours degree in sociology, ninety were taking a course leading to a Certificate in Social Science (later renamed the Diploma in Social Administration) and twenty five graduate students were taking the same course in one year. The Department also provided four one-year professional training courses designed in the main for graduates in social sciences: the Personnel Management course for about twenty five students, the Mental Health Course [established in 1929] for about thirty five students training for psychiatric social work, the Child Care Course for about twenty students training to work in local authorities' children's departments and involuntary child care organisations, and the Applied Social Studies Course for about twenty five students entering various branches of social work. A number of graduate students were reading for higher degrees, and various others were temporarily attached to the Department." The School ceased to offer professional social work qualifications in 1998.

3 **Woodbrooke College** was the first of the Selly Oak group of collaborative inter-church educational colleges in Birmingham established in the first half of the 20th century. Founded in 1903 as a residential study centre for the Society of Friends.

4 **Blue Triangle Clubs** were originally set up by the Young Women's Christian Association for working girls who had lost their jobs as a result of the First World War and by 1918 there were more than 100 clubs. The clubs were further developed in the 1920's and 30's.

5 The Charity Organisation Society (COS) was founded in London in 1869 and led by Helen Bosanquet (1860–1925), social theorist and social reformer and Octavia Hill ((1838–1912), housing and social reformer. It supported the concept of self help and limited government intervention to deal with the effects of poverty. The organisation claimed to use "scientific principles to root out scroungers and target relief where it was most needed". It organised charitable grants and pioneered a volunteer home-visiting service that formed the basis for modern social work. The original COS philosophy later attracted much criticism though some branches were much less doctrinaire than others.

Gradually volunteer visitors were supplanted by paid staff. In 1938 the COS initiated the first Citizens' Advice Bureau, and continued to run CABx branches until the 1970s. The COS was renamed Family Welfare Association in 1946 and still operates today as Family Action a leading provider of support to disadvantaged families. [For more information, *see* Charles Loch Mowat *The Charity Organisation Society 1869-1913* (1961), Madeline Rooff *A Hundred Years of Family Welfare: A Study of the Family Welfare Association (Formerly Charity Organisation Society) 1869–1969* (Michael Joseph 1972) and Jane Lewis *The Voluntary Sector, the State and Social Work in Britain* (Brookfield 1995). Michael J.D.

Roberts, in an article *'Charity Disestablished? The Origins of the Charity Organisation Society Revisited, 1868-1871'* in the Journal of Ecclesiastical History (CUP 2003, vol 54 pp40-61)].

6 **Social work courses**. It is not entirely clear which of the older courses MB is referring to here: possibly those for psychiatric social workers, almoners, and children's officers. For further discussion see Rosalind Chambers (1959) *Professionalism in Social Work* which forms Appendix 2 to Barbara Wootton's *Social Science and Social Pathology*. And Ann Davis (2008) *Celebrating 100 Years of Social Work* University of Birmingham.

7 **Birmingham Settlement .** Founded in 1899, the Settlement is the one of the oldest charities in the city and formed part of a movement of social reform activists outraged by the plight of the poor in the 19th century. Originally the work concentrated on providing support to women and families in the very deprived area of St Mary's, now known as Newtown. The Settlement developed a reputation for innovation and commitment to high standards and had close links with the Social Work Department of the University.

8 **Dr William Moodie**. Served as General Secretary of the Child Guidance Council. In 1927 the Jewish Health Organisation opened the East London Child Guidance Clinic under Dr. Emanuel Miller; this was the first clinic in this country directly based on the American pattern. Two years later the London Child Guidance Training Centre was opened as a clinic in Islington under his professional direction and with financial support from the Commonwealth Fund.. This clinic was the first centre in this country in which psychiatric social workers as well as psychiatrists and psychologists could be trained.
Moodie's publications included : *The Doctor and the difficult adult* and *Child Guidance***,** both published in 1947.

9 **Canonbury Child Guidance Clinic** was an alternative name often used for the London Clinic and simply refers to the district of London where it was located.

10 **Maudsley Hospital.** The foundation of the Hospital dates from 1907 when Dr Henry Maudsley offered the London County Council a substantial sum for the creation of a new mental hospital. Because the first world war intervened, the LCC did not assume control until1923. The Hospital gained a high reputation for the training of nurses and for the inter-disciplinary teamwork of its children's department. There was considerable expansion in the1920's and 30's. A Child Guidance Clinic was opened in1928 by Dr William Moodie. The children's inpatient unit followed in 1947. Several of Alan Cohen's interviewees had contact with the adult's and children's departments.

The Hospital was also recognised for the quality of its teaching and research. A Medical School was established in1924 and became a pre-eminent postgraduate centre for mental health medicine, eventually evolving in 1946 into the independent **Institute of Psychiatry,** which shared the south London site with the Hospital.

11 and 12. **Nancy Fairbairn** and **Molly Lawden**. Two influential PSW's whom John Bowlby credited with introducing him to the idea that parental conflict and family environment had an impact on the child's emotional development.

13 **Margaret Ashdown** (1892-1962) was an early psychiatric social worker and a leading member of the Association of Psychiatric Social Workers (APSW). She was a tutor at the London School of Economics for several years and edited the *British Journal of Psychiatric Social Work*: a tribute to her by Sybil Clement Brown was printed in that journal in 1962 - Volume 6, no 3.

14 **The Association of Psychiatric Social Workers (APSW)** was the main professional body for social workers looking after the welfare of mentally ill people in the United Kingdom from 1929 to 1970 in which year Association merged with six other social workers' organisations to form the British Association of Social Workers (BASW). The archives of the seven organisations are lodged, and listed online, with the Modern Record Centre at the University of Warwick. R.T. Stacey and A.T. Collins (1987) assembled the *Catalogue and Guide to the Archives of the Predecessor Organisations 1890-1970* published by BASW.

15 Ashdown, M. (1953). **Social service and mental health**: an essay on psychiatric social workers. Contributor Sybil Clement Brown. Routledge and Kegan Paul.

16 **Sir Aubrey Lewis** (1900-1975) first Professor of Psychiatry at the Institute of Psychiatry, London – which was the designation given to the Maudsley Hospital Medical School in 1946. He had a profound influence in the development of psychiatry in the UK, partly through his own work and published papers and lectures, partly through his influence on many of his students. From a Jewish family in Adelaide, he attended a local Catholic school and went on to graduate as a doctor from the Adelaide University Medical School and then practice in the City's Hospital. Awarded a Rockefeller scholarship, he trained in the USA, Germany and England and became thoroughly committed to psychiatry. In 1928 he obtained the membership of the Royal College of Physicians and went to the Maudsley Hospital, London, first as a research fellow, and from 1929 as a member of the clinical staff. He remained there until his retirement.

During the thirty years of Lewis's leadership the hospital and institute emerged as a postgraduate research and teaching centre of world rank, with a leading position in the United Kingdom. Around himself Lewis established a group of research workers who transformed British psychiatry from a clinically orientated study to a respected academic discipline with foundations in the empirical sciences, particularly epidemiology, psychology, neuroendocrinology, neuropathology, and biochemistry. He helped to train a generation of psychiatrists who later occupied many of the principal psychiatric posts in the United Kingdom and elsewhere. Although Lewis wrote no books, he published numerous papers, notably on melancholia, neurosis, history, and biography. He was particularly interested in social and economic influences on mental illness. In 1942, for example, he was honorary secretary to the neurosis subcommittee of the Royal Medico-Psychological Association which examined the relevance to psychiatric disorders (such as neurosis) of poverty, occupation, unemployment, and housing.

He is remembered primarily for his creation of an internationally recognized institute for psychiatric research and training. [Further information available from: Royal College of Psychiatrists online Archive No 14.]

17 **Janet Jackson** was a psychiatric social worker who previously worked in the Genetics Department of the Institute of Psychiatry. The Aubrey Lewis archive at King's College, London has a letter from her to Aubrey Lewis requesting a reference for the Assistant post at LSE referred to by MB.

18 **Moral Reform**. This could be a reference to Moral Re-Armament (MRA) movement which launched in1938, or to being a Moral Welfare Worker and membership of the Moral Welfare Workers Association.

19 Three authors who wrote about human sexuality and variations in sexual behaviour.

20 The **1930 Mental Treatment Act** was the consequence of a Royal Commission that sat for 4 years until 1929. Its breakthrough clauses allowed a person to apply to become a voluntary –and therefore temporary – patient ; and also to have out patient services at psychiatric hospitals.

21 **West Park Hospital** opened in 1923 and was the last of the five large LCC hospitals to be built to the west of Epsom in Surrey. Together with West Park, Horton, Manor, Long Grove and St. Ebba's were referred to as the "Epsom Cluster". At maximum capacity each could have over 2,000 patients.

22 **1890 and 1891 Lunacy Acts**. The history and some of the complexities of these Acts can be found at the National Archives. The usual caveats about the offensiveness of the historical terms used should be entered. The Acts provide for some judicial protection for the person deemed to be a lunatic; and regulate to some degree matters such as lunatics placed in workhouses, private asylums, reception orders, restraint, discharge, escape and recapture.

23 The reference here is to the **1946 National Health Service Act** which paved the way for the introduction of the NHS in 1948.

24 The Greater London Council (GLC) was the enlarged successor body to the London County Council (LCC) and operated from 1965 to 1986. Its archives were placed with the London Metropolitan Archive.

25 The LCC inherited a large number of asylums in 1888 and was responsible for their day today running and for planning new hospitals to meet growing demand. These tasks were devolved to the **LCC Asylums Committee** who were obliged heed the early 20th century forecasts of the Lunacy Commission that a huge building programme was required.

26 **Evelyn Fox** (1874 -1955). Leading campaigner for better services and better understanding of mental disabilities and mental illnesses and the distinctions between them. Her long involvement in statutory and voluntary bodies, including five years service on the Wood Committee on the education of children with special needs, made her a feared and respected advocate. For a fuller portrait see *The Nature of Special Education* by Tony Booth and June Statham.

27 **Mental After Care Association (MACA).** A very early community based mental health charity which was originally called The After-care Association for Poor and Friendless Female Convalescents on Leaving Asylums for the Insane. Initially, the Association helped find temporary homes and placements in service for women coming out of asylums, working alongside them as they tried to regain a normal life. Soon after, it began preventive work by placing "people at risk of becoming insane" in cottage homes and set up the first residential care home in England for people with mental health problems. The Charity is now known as Working for Well-being.

28 **Elisabeth's Act 1601** required each parish to be responsible for its own poor. JPs had to set up a framework for the administration of the law.

29 **The Mott Clinic**. See Rollin, H. (1994) *The Horton Malaria Laboratory*, *Epsom Surrey (1925—1975*). Journal of Medical Biography.

30 **Anne le Mesurier** was the senior PSW at St. James Hospital, Portsmouth from 1946 to 1952 and worked closely with Dr Thomas Beaton (see also note 32 in the MYERS interview, no. 15). She was viewed as invaluable in the functioning of an integrated mental health service. For a fuller account see Hugh Freeman, *The Portsmouth Mental Health Service 1926 - 52* in *The Medical Officer*, March 1962.

31 The APSW publication with this title was published in 1959 and was based on a symposium held at Leicester University in 1956. The contributors include some of Alan Cohen's interviewees: Jean Snelling and Elizabeth Irvine.

32 **Mary Richmond** (1861-1928) was a well known American practitioner, teacher, and theoretician who formulated the first comprehensive statement of principles of direct social work practice. Concerned about the frequent failures of people to respond to service, in 1897 she delivered her historic speech at the National Conference of Charities and Correction, calling for schools to train professional social workers. In 1899, she published the first comprehensive presentation of practical suggestions: *Friendly Visiting Among the Poor.* Her most celebrated book, *Social Diagnosis,* was based on her lectures and on her wide readings in history, law, logic, medical social work, psychology, and psychiatry.
