A history of mental health nursing: a personal perspective
by Felicity Stockwell, retired mental health nurse and lecturer

Nursing care of the mentally ill was formalized in 1885 with the publication of *Handbook for attendants on the insane*. Large numbers of asylums had been built throughout the century, in which conditions were austere and 'treatment' of any disturbed inmates was very punitive. Philippe Pinel, in France, removed the chains and harsh punishments from his patients and showed that kindness and better conditions dramatically improved their behaviour. His ideas were taken up by some doctors in the asylums, and they realized that education of the attendants was essential if improvements were to occur. In the aforementioned handbook, attendants were advised that kindness and the encouragement of activity amongst the inmates were the most important aspects of their role.

By the twentieth century, attendants had become 'nurses', whose training included some lectures and a qualifying examination. However, very little was known about the causes and treatment of mental illnesses and controlling disturbed behaviour was all important. The nursing 'ethos' became 'benevolent constraint'. This was characterized by physical constraint in the form of locked wards, with especially secure wards for those who did not comply. Psychological constraint was evident in the employment of rules and routine, a lack of privacy, the prohibition of personal possessions, and a lack of any engaging activity. This resulted in patients who were apathetic and docile and did not cause any trouble.

As the century progressed it was coming to be understood that all forms of mental illness cause distress through interfering with social relationships, and that while controlling behaviour, the mental hospitals reduced, rather than enabled social skills.

In 1930, The Mental Treatment Act was passed and that allowed mentally ill people to sign themselves into hospital as 'voluntary' patients, with the understanding that at least some of them would become well enough to be discharged.

Some of the mental hospitals set up 'acute' wards; however, staff psychiatrists and nurses lacked sufficient training and incentive to change their ways and modernize the service. Because these wards were not meant to be locked, the benevolent 'constraint' became benevolent 'coercion', with the final sanction of compulsory detention and a transfer to a secure ward if the patients did not, or could not, comply in a docile manner with such coercion.

The mentally ill have always been stigmatised by society, and the nurses working in the mental hospitals throughout the country have also been side-lined, if not stigmatised, both by society and by general nurses. The nurses, who were initially recruited from the surrounding countrside, had to make for themselves a comfortable way of life which resulted in, what I term, a mutually rewarding symbiotic relationship with the patients. The patients were cared for with kindness and the physical care could be excellent, but it was not in the nurses (subconscious) interest for them to be helped to recover or gain any social skills.

Despite the inertia in the mental hospitals, there were always some psychiatrists and nurses who tried out some more beneficial ways of caring. By the early 1950s several developments provided an impetus for change, resulting in several individuals devising strategies for dramatic improvements in care in their own work situations. Such developments included:

• Freud's ideas, which had begun to give better understanding of some aspects of mental illness.
• The experiences of psychiatrists caring for mentally ill troops in WWII.
• The discovery of chlorpromazine.
• New ideas from America.

When I decided to do my mental health nurse training, in 1957, I chose to go to a hospital where the matron and principal tutor were members of a self-support group in London who were pioneering change. I had visited several other large mental hospitals and chose this one because of the enthusiasm of the staff and the cheerful atmosphere in the wards. It took me a while to realize that, in those days when male and female patients were strictly segregated, the male and female students had completely different learning experiences in the wards. It also took me many years to realize that the training I received was far from universal.

In the Training School we were taught, under the heading of developmental psychology, that as the newborn infant is suckled and fondled by the mother, it 'learns to need' love and approval from her. By a very complex process in the midbrain, which has come to be called 'bonding', this 'need for approval' becomes incorporated into the monitoring system for physical needs.
This monitoring system has the purpose of 'maintaining homeostasis' throughout the body and preparing the body to respond to threat and danger. It achieves this with the physiological processes of the autonomic nervous system and endocrine glands. Once bonding has occurred, the same physiology monitors, day and night, the degree to which the needs for approval and belonging are being met, and responds with the same alerting changes in the body that we experience as anxiety. With physical lacks or threat, the body quickly reverts to its state of equilibrium once the need is met or danger averted. However, this is not the case with psychological lack or threat, and linked memory circuits maintain the state of arousal of anxiety, which leads to stress that is, in varying degrees, debilitating.
There are some 'mechanisms' built into this system by which the knocks to self-esteem are distorted as they reach our awareness, and where there is severe lack of approval their overuse can lead to various neurotic disorders. The behaviour that arises from these disorders alienates other people and makes it even less likely that the need for approval will be met.
When a person has a psychotic disorder, the physical pathology leads to strange thoughts, feelings, and behaviour, which are frightening in themselves but also alienate others, so that the bonding system needs will also not be met and additional levels of stress will be generated.
It is the bonding process that mediates the trait of sociability, which is what makes us uniquely human, and the common denominator of all mental illness is that sufferers feel cut off and lonely in the midst of the crowd. It was this understanding that influenced the organization and practice of nursing in the wards where I did my training.
It is only possible to give a brief synopsis of the changes that had been introduced. The major one was of the fundamental philosophy that the people in our care were not primarily 'mental patients', but were people who had many aspects that were fully functional and needed exercising, and that their present difficulties were but a part of their life on Earth.
The most important aspect of the patients' normality was seen as being the

'bonding process system' and the fundamental contribution of nursing was to ensure that every individual's needs for approval (love and friendship) and sense of belonging (popularity) were met, and that they learned what they had to offer and how to give it, in a social situation.

To translate that philosophy into nursing care that would be 'therapeutic', the first emphasis was put into creating a social environment in the wards that was comfortable and enabling of friendships, and where nurses were companions rather than providers of care.

The next emphasis was on ensuring teamwork, within the nursing team and with the doctors and other contributors to the patients' care. Here it was recognized that every member of the team had differing skills and abilities to offer and all were of equal value, and that in enhancing people's self-esteem, smaller contributions from many is much more effective than a lot from one. Boredom had become the biggest problem for patients in the big mental hospitals, and boredom arises when there are no opportunities for getting one's needs for approval met. So the matron banned boredom! Instead she instigated programmes of activities in all the wards that had to be timetabled and were monitored by her assistants. Patients and staff participated and contributed equally to whatever they had put on the timetable. It sounds frenetic but not everyone was doing everything all of the time.

Of course there were always some patients who needed more individualized care, but the atmosphere and attitudes were very tangible and even the most disturbed patients could quickly feel safe and valued. By reducing the anxiety arising from 'unmet needs, the disturbed behaviour caused by the illness was also reduced.

When I completed my training in 1959, I went as a ward sister to a ward for the acutely mentally ill, situated in a general hospital. It was an exciting time. The new Mental Health Act was about to be passed, and there was news of various hospitals or units putting new ideas into practice.

The psychiatrists in the ward where I worked were in complete accord with the way of nursing that I had been taught. Their belief was that there would be a physical means of treatment for all mental illnesses one day, and with the arrival of antidepressant and anxiolytic drugs, they thought that a nursing input would become unnecessary.

I came to realize that it was only because of the nursing input that any of the treatments were effective at all. Pills sent by post will not do any good at all. Physical treatments for mental illness, given where the patient has trust in the doctor and where hope is given, will allay some symptoms, but the help given to re-engage with social life and find some contentment only comes from the nursing contribution.

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In conclusion, I look at mental health nursing today with sadness, the enthusiasm and imagination of those pioneers failed to inform and inspire the rest of the professionals. When I went to work as a tutor in one of the big mental hospitals in the mid 1970s, I found some cosmetic changes but the ethos and attitudes were the same as ever. Lip service was paid to behaviour modification and industrial therapy but they were readily institutionalized.

In the School of Nursing there was no mention of 'nursing' or social skills or developmental psychology in the syllabus, and in the wards there was passive and active resistance to any changes.

The community psychiatric nurse training, which was more forward looking, started soon after, but the ethos became more one of management and

problem solving. Clients were taught social skills, rather than being socially enabled, using the understanding of the bonding process.

Then the hospitals were closed and hundreds of nurses who, through no fault of their own, had become 'institutionalized', were redeployed in the community and in acute units, and became the teachers, and more recently, the lecturers, of the later generations.

Remembering that, throught the history of mental health nursing, there have been enlightened individuals who have generated pockets of excellence, and influenced improvements. However, the heavy hand of history still prevails in influencing much current practice and with the move to nurse education in the universities, and the increasing demands placed on nurses by political and management strategies, the chances of generating a body of skilled, well resourced, well motivated Mental Health Nurses, seems to me to be remote, and I feel sad that so many individuals who start their careers, with enthusiasm, find themselves frustrated and undervalued by the realities of their experiences.