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Mind the Gap: MIND, The Mental Hygiene Movement and the Trapdoor in Measurements of Intellect

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Abstract

The National Association for Mental Health adopted the ‘brand name’ MIND as part of its transformation into a campaigning pressure group at the turn of the 1970s. This article examines the historical antecedents to key statements made by the organisation at this time regarding the relationship of mental health with, what was then called, ‘mental handicap’.

The National Association for Mental Health is placed within the historical context of the movement for mental hygiene. The article traces how the movement theorised mental health as critically related to intellect and emotionality.

The movement relegated people deemed ‘mentally deficient’ from therapeutic policies based on family relationships believed to promote mental health. However, a late 1950’s experiment known as the Brooklands Study subverted this discrimination. This was paradoxical since it built on mental hygienist theorising.

Theorisations of the relationship between intellect, emotion and mental health are still potentially discriminatory.

Keywords

Mental Health; Mental Hygiene; Emotionality; History; Intellectual Disability; Mental Handicap; Mental Deficiency; Brooklands

In 1970, the National Association for Mental Health (NAMH) announced its intention to begin a major national campaign. The aim would be to raise the profile of mental illness and what was then called mental handicap among the establishment and the public (National Association for Mental Health 1970). From this point onwards NAMH would pursue a role as a pressure group. It soon adopted the ‘brand name’ MIND and embarked on campaigning for patient rights.

One important impetus for this rejuvenation of NAMH was the series of hospital scandals that had begun to emerge from the mid-1960s (Martin 1984). Those at Ely and Farleigh mental handicap hospitals were highly significant. NAMH made specific reference to them in the context of its planned campaign. At this time there were some 60,000 children and

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adults living segregated lives in mental handicap hospitals under the remit of the mental health services. NAMH raised a number of forceful questions about their care. It remarked:

> The concept of treatment for the mentally handicapped in hospitals embodied in the Mental Health Act has never been sufficiently discussed. What is this treatment? Who should undertake it? To what extent are these hospitals 'homes', and if homes, how 'homelike' are they? (National Association for Mental Health 1970, p.4).

Regarding the children living in these hospitals NAMH asked, 'Have the findings about maternal deprivation, so familiar to the child-care world, been applied to the grossly handicapped child in hospital?' (National Association for Mental Health 1970, p.4). Of its own role regarding these issues NAMH concluded that:

> Our main concern is with the individual and his mental health, whatever his innate intellectual capacity. That the ability of the mentally handicapped to enjoy life should not be impaired by a lack of human warmth, appropriate assessment and every opportunity for self-fulfilment (National Association for Mental Health 1970, p.4).

The issues raised by NAMH here can be viewed as displaying two inherent claims. One is that the intellectual capacity of individuals is not a measure of their mental health. It follows from this that a categorisation made in terms of a person's supposed mental capacity should not determine the form of that person's care. The other inherent claim is that mental health is fundamentally related to close human relationships, and that the most appropriate model for those relationships is the home and the family.

This article unpacks these claims by placing them in a historical context. It reveals that NAMH had in fact been an important element of a psychiatric strategy which had developed one of the two claims made above, but had done so on the basis of denying the other claim. That is, it developed an influential concept of mental health envisaged as largely derived from the close human relationships of the family. But its development of this view of mental health entailed a related claim that measurements of supposed 'intellectual incapacity' precluded some people from ever achieving the adequate mental 'adjustment' associated with mental health. One consequence of this was that, when it came to mental health care and treatment, people considered to be 'mentally deficient' were relegated from the type of care promoted for other people.

This article is divided into four sections. From its formation NAMH was an important institution associated with what was known as the movement for mental hygiene. The first section places NAMH within the context of this movement. It describes how the movement introduced emotionality as a fundamental element of the development of mind and how, in turn, it related this to family relationships as the key to successful 'adjustment' and mental health. The second section describes the way in which the mental hygiene movement used history as an authoritative support for its claims. It interpreted mental health in terms of 'mental adjustment' and founded this on an understanding of history as the progressive development of the mind, from 'the primitive' to the rational and 'civilised'. Section three shows that this description of mental adjustment entailed what amounted to a conceptual trapdoor. People considered to be below a certain level of intellect were deemed unable to

benefit from the close emotional relationships associated with the family that were essential for other people. Section four suggests one reason why, by 1970, NAMH had come to deny that a measurement of intellectual deficit in itself represented mental-ill health, while at the same time the organisation retained a view of mental health as fundamentally related to the close emotional relationships associated with the family. It shows that the influential 'Brooklands experiment' which was carried out in the late 1950s can be understood as, in part a beneficiary of the mental hygiene discourse, and in part an element of its subversion.

Mental Hygiene and Emotionality

NAMH was officially founded just after the Second World War in 1946 (National Association for Mental Health 1947). It was a voluntary organisation that worked closely with psychiatrists and the government, providing residential services, educational courses for medical professionals and more general information for the public. The organisation was, in fact, formed through the amalgamation of three earlier organisations that had, along with a fourth, constituted the institutional nucleus of the movement for mental hygiene that had emerged between the wars.

Although the term 'mental hygiene' had been in use in the nineteenth century, its use to represent a movement and associated practice began in the United States in the first decade of the twentieth century (Quen 1977) At first its aim was to improve the care and treatment of people in mental asylums. But the movement's instigator, and one time mental patient, Clifford Beers was soon persuaded by influential allies in medicine and psychology that the movement should focus on the prevention and early treatment of mental problems (Porter, 1986, p.194-5).

The organisations that became associated with the movement for mental hygiene in Britain followed the same focus. The earliest organisation was the Central Association for Mental Welfare (CAMW), founded in 1913. The immediate cause of its creation was the institution of the 1913 Mental Deficiency Act. Under this Act all county and county boroughs in England and Wales were to ascertain the local population of people deemed 'mentally defective', provide institutional provision, and arrange community supervision (Thomson 1998, p.217). The Act also founded a Board of Control to oversee the whole of the mental health system. The Board assisted in the creation of the CAMW and the two held a close association through the interwar years (Thomson 1998, p.153).

So-called 'mental deficiency' was associated with what was termed 'social inefficiency' and, in turn, to a host of social problems.

Under the 1913 Act local voluntary organisations could appoint themselves to survey the local population and ascertain people considered 'mentally deficient'. These people were to be notified to the authorities for certification. Local associations also provided supervision and guardianship for people where institutional provision could not be provided. The CAMW set itself up as the central training and co-ordinating body for these voluntary organisations. Partly through its association of 'mental deficiency' with 'social inefficiency' the CAMW increasingly extended its activities to encompass other people considered to be on the so-called 'borderline' between apparent 'pathology' and 'mental health' (Jones 1986,

p.27-8). Through this the CAMW combined with other interwar organisations in the formation of a movement for mental hygiene.

The CAMW's concern with 'mental deficiency' and its relation to serious social problems, was shared by the National Council for Mental Hygiene (NCMH). This was founded in 1922 by members of the Medico-Psychological Association. The NCMH's terms of reference for its sub-committee on mental deficiency, for instance, associated it with 'criminality, dependency, vagrancy, prostitution, and allied social problems' (National Council for Mental Hygiene 1932, p.21). But the NCMH also related 'social inefficiency' and social problems to 'psychoneuroses' and, what were termed, 'functional nerve disorders'. It emphasised the need for prevention and early treatment in the interests of the 'health of the community' (Thomson 1922; Boyle 1928). It therefore gave itself the role of promoting and co-ordinating already existing organisations working, not only in mental deficiency, but also in the study and treatment of mental illness and milder mental disorders.

The NCMH's formation had been promoted by leading figures at another key organisation of the movement for mental hygiene. This was the Tavistock Clinic. It was one of the most influential of the clinics dedicated to psychotherapy for 'psychoneuroses' and 'functional nerve disorders'. From the outset the Tavistock conceived its role in terms of preventing and treating mental troubles in the community through a strategy of mental hygiene (Dicks 1970, pp.1-4).

All three of these organisations cast their mental hygiene approach as an essential public health measure. One result of this was their promotion of another key organization of the mental hygiene movement. This was the Child Guidance Council (CGC), founded in 1926 (National Association for Mental Health 1947, p.5). Both the NCMH and the CAMW believed child guidance clinics to be central to providing comprehensive mental hygiene for the community (National Council for Mental Hygiene 1933). Ensuring mental adjustment during childhood was considered crucial to prevent later, and more serious, mental problems and the social problems assumed to be associated with them. The home and family were seen as crucial for the production of mental adjustment, 'social efficiency' and responsible citizenship. Indeed, for mental hygienists, the three could not be separated. The Child Guidance Council aimed to promote the establishment of guidance clinics to treat children considered to be showing signs of maladjustment. Along with the rest of the movement it also disseminated propaganda on the 'healthy' and responsible upbringing of children, to parents, teachers and allied professionals.

Other than the CAMW, these institutions were, from their foundation, strongly influenced by psychoanalysis. More particularly, they promoted a generalised derivative of psychoanalysis known as 'the new psychology'. Psychoanalysis had made some inroads into psychiatric and psychological thinking before the First World War. It had also had a certain impact on the wider reading public. But its reception in Britain was uneven and controversial. In general, those British psychologists and medical doctors who were receptive to psychoanalysis gave it a qualified acceptance (e.g. Hart 1910; Brown 1914). The wartime phenomenon of 'shell-shock' provoked further interest. Among doctors who treated the condition, a concept of mental disorders as 'functional' rather than based on

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'brain disorders' gained wide acceptance (Stone 1985). The apparent need to analyse and understand unconscious motivations, coupled with the therapeutic value of 'talking therapies', became established as important areas for activity.

The interwar mental hygiene movement paid great attention to such mental disorders with their attendant unconscious motivations, and termed them 'maladjustments' of the personality. These unconscious motivations lay in the emotional substrates of the mind. They were recalcitrant emotions. But they could not simply be suppressed by an act of 'will'. As Walter Langdon Brown (1933) put it at a conference on mental hygiene in 1933, 'The will cannot control what it does not understand'. Maladjustment of the personality was largely a matter of subconscious reactions and needed to be understood by 'exploration and explanation of the underlying causes.' The mental hygiene movement claimed an expert knowledge of the emotional economy of individuals, its stages of normal development, its deviations or, as they termed them, 'maladjustments', and clinical measures necessary for its rehabilitation (e.g. Craig 1933; Rees 1929). The essential claim of the mental hygiene movement here, was that rational thinking had finally grasped the fact that emotional experience underlay all growth and adjustment. Humans were dynamic organisms. Emotional experience was a necessary component of this. To understand and craft these emotions was to be both rationally enlightened and more 'humane'. It would enable personal and social harmony and, at the same time, the continued progress of 'civilisation'.

Progressive History and the Development of Rationally Marshalled Minds

If what rested at the heart of the mental hygiene movement was a discourse of emotionality, this emotionality was nevertheless disciplined and secured within an ordering of the past as made up of progressive stages of development. Historians and other academics have mainly located the mental hygiene movement within a description of an ever widening psychologisation of society that has taken place from the early twentieth century (e.g. Rose 1985; Rose 1989; Hendrick 1994; Jones 1999). The terminology of 'adjustment', for example, can be understood as enabling an extension of the psychiatric sphere of influence outside the asylum. Through this means, it is argued, psychiatric and psychological experts were able to sell themselves as uniquely qualified to mediate 'mental health' and 'good citizenship'. This seems certainly correct. But the discourse of emotionality with its attendant terminology of 'adjustment' informed the psychologisation associated with the mental hygiene movement in a particular way. It provided a conceptual link between history, society and the individual. History was deployed as part of the means to define the essentials of personhood, its mental health and its deviations.

The terminology of adjustment derived from biology. Along with other associated biological concepts, such as 'organism' and 'function', the notion of 'adjustment' had been applied to ideas about human psychology and social evolution since the mid-nineteenth century. Indeed, the terms 'adjustment' and 'maladjustment' had entered studies of child psychology from this time (Keir 1952). Intrinsically linked to the use of these terms in psychology was the notion of progressive human and social history. By using this notion of adjustment mental hygienists were able to situate their outline of human development and mental health, on pre-existing depictions of the past as a process of progressive change. The

individual was an organism actively engaged in development and adjustment to its environment.

Much nineteenth-century western thought had cast the past as a progression of stages in the development of the rational individual mind and a concomitant ‘civilisation’ of society (Bowler 2003). The mental hygiene movement reiterated this (e.g. Brown 1935; Gordon 1933). Life was either progress or regression (Crichton Miller 1926). But, employing the new psychology, mental hygienists described this ‘progress’ or ‘regression’ in terms of emotionality as well as intellect. The psychoanalyst Ernest Jones wrote in the NCMH journal *Mental Hygiene* that the child effectively condensed ‘a hundred thousand years of mental evolution’ as it endeavoured to adapt itself to ‘civilized standards’ (Jones 1933, p. 84). Mental hygienists echoed this. The child psychiatrist Emmanuel Miller, maintained that in ‘primitive’ society individual emotionality was dealt with by quickly bringing it under communal control and convention. But this had the effect of stultifying individuality and freedom. By contrast, in ‘civilized’ society the individual ‘mind’ had superseded the group ‘mind’. Individual intellect now controlled and rationalized instincts and emotions. But it achieved this ability through the temporary and less severe role of moral authority played by the modern family. Through its intimate relations of authority the modern family constrained the ‘primitive’ instincts of the child and structured the developing mind (Miller 1938b).

But mental hygienists also warned that primitive emotions still exercised hidden power and were an intrinsic aspect of personhood. They needed to be understood if they were to be controlled. Wielding the new psychology they combined a description of instinctual ‘needs’ with an elaboration of how these were moulded through experiential stages of development. The aim of mental hygiene, as the psychiatrist J R Lord (NCMH 1930, p.13) grandly characterised it, was ‘the dominance of reason over emotion in the moulding of personality in such a fashion as to bring out the finest traits of human character’.

For mental hygienists then, humans were emotionally endowed and this was an intrinsic and important aspect of personhood. But, since they prioritised reason and individual intellect as the pinnacle of civilised development, mental hygienists considered a healthy personality to be quintessentially about the understanding and thus management of the emotions by the rational mind (e.g. Craig 1933).

The Trapdoor in Measurements of Intellect

It was, however, this very prioritisation of intellect and progressive history that, in fact, entailed the construction of a conceptual ‘trapdoor’ in approaches to care and treatment.

One of the major benefits, for mental hygienists, of coupling the individual, society, and progressive history together through the terminology of adjustment was that it also allowed a continuity to be drawn between diverse individual and social ‘problems’. As one mental hygienist put it, ‘The social ills of the “backward” child, the persistent thief, the sex offender, the acute depressive and the “unmanageable” rebel are not different problems but in reality a single one, that of helping the sufferer to a better adjustment of life, in short, of restoring to him mental health’ (Central Association for Mental Welfare 1939). Likewise, an influential report by mental hygienists at the end of the 1930s claimed that mental health

should be conceived and dealt with as a single concept encompassing mental deficiency, mental illness – whether considered functional or organic – and, minor mental problems (Feversham Committee 1939; Herd 1939). The board of Control supported these views (Provisional National Council for Mental Health 1943b).

This assertion of a continuum encompassing people termed ‘psycho-neurotic’, ‘borderline’, ‘functionally’ or ‘organically mentally ill’, or ‘mentally deficient’ implies a continuum of humanity. All human life and behaviour is part of this continuum, and the thread that joins the whole is the social and individual need for adjustment. It is here however, at the heart of this apparent continuum, that there lies a trapdoor. It is the trapdoor of intellectual deficiency. Above the trap lies the assumption that family relationships are the crucial arena within which the rational and civilised adult emerges and becomes mentally adjusted. Beneath the trap lies a different assumption. This is that a deficiency of mental capacity precludes the need for this family environment.

Child guidance clinics discriminated against the treatment of so-called mentally deficient children. ‘The study of mental deficiency’, wrote Emanuel Miller, ‘is concerned with the thinking (cognitive) or intellectual handicaps, largely because intelligence rather than any other function seems to suffer… .’ This was the accepted view. Mentally deficient children’s emotional lives and behaviour difficulties were therefore largely deemed mere consequences of intellectual incapacity. They were different to other children, whose ‘maladjustments’, ‘although manifest in symptom and behaviour’, were conceived as the *products* of emotional difficulties (Miller 1938a, p. 208).

Here was the trapdoor in measurements of intellect made manifest. Beneath a certain level, any detailed analysis of emotions and relationships in the home, became valueless. These children were the products of arrested development. Intellect deemed deficient was the sign that their emotionality was largely ‘primitive’, that the intellect could not craft and shape it, and that the home environment was therefore not important to its ‘adjustment’.

The mental hygiene movement agitated for increased ascertainment and segregation of people considered mentally deficient throughout the interwar years (e.g. Feversham Committee 1939, para 85). The attitude to children considered mentally deficient is exemplified by the following excerpt from a pamphlet produced by the CAMW in the 1930s (Fitzgerald 1939, p.47):

> It is a well-known fact that a child who has been trained for years in an Institution will deteriorate in the most deplorable fashion as a result of a few months idleness at home. In the same way, too, a low grade child left continuously without training is likely to remain helpless, dirty and uncontrolled; an almost intolerable burden on the Institution to which he must ultimately be sent.

The Brooklands Experiment

After the Second World War the numbers of children and adults certified and detained within the mental deficiency system continued to grow. As we have noted, before the war people labelled mentally deficient had relevance to mental health only to the extent that they

threatened its development in other individuals and in the community at large. Mental deficiency was reified as a social contagion; it had a ‘tendency to perpetuate itself by creating an environment inimical to the development of normal mentality’ (Central Association for Mental Welfare 1934). After the war, however, the mental hygiene movement quietly shifted away from its focus on mental deficiency as a principal cause of mental ill-health and social problems in the community. In 1948, for instance, the movement held the Fourth International Congress on Mental Health in London. J.R. Rees, the President of the Congress, described its aim as ‘to focus interest on the sickness of groups and communities in the world’ (Rees 1948, p.36). At previous congresses this would certainly have encompassed the ‘social problem’ of mental deficiency. But this time little attention was paid to the issue. In part this can be attributed to an attempt to distance mental hygienists from racial hygiene measures associated with the Nazi regime. In part also, it can be attributed to a perception that Fascism and the war had shown that whole nations could display the symptoms of mental disorder. Mental hygienists continued to focus on emotionality and its development within family relationships as crucial for mental health, understood as full mental adjustment and good citizenship. People deemed deficient intellectually continued to be considered incapable of developing adequate emotional maturity. But the more widespread threat to the mental health of communities appeared to lie in the faulty adjustment of people who were not fundamentally ‘mentally deficient’. Faulty or inadequate emotional relationships in the home became the paramount issue to be confronted here (e.g. Flugel 1948; Tredgold 1949). By fiat mentally deficient people had been defined and categorized as a threat to the health and progress of humanity. Now, by fiat, they were apparently much less so. But, while people labeled mentally deficient were now not apparently the primary cause of social ‘retardation’ or ‘regression’, they were also ruled out of being significant participants in the ‘healthy’ development of civilization under the rubric of a science of human relations.

What then had changed by 1970? Why did a reconceptualisation of mental health in relation to notions of intellectual incapacity emerge at NAMH at this time? One answer to this question is suggested by an influential experiment that took place in the late 1950s. This was the Brooklands experiment. Its importance lies in the fact that it appears to have extended the original mental hygiene conceptualisation of mental adjustment but, at the same time, subverted it.

Brooklands was a three-storied, late Victorian house with a large lawn and gardens. Between 1958 and 1960 it became home for a group of children then categorised as ‘imbecile’, and the site for an influential experiment carried out by the psychologist Jack Tizard and his colleagues (Tizard 1964). The thesis of the experiment was straight-forward; it was that the upbringing of mentally handicapped children in mental deficiency institutions should be measured against the accepted principles of care for other children deprived of a normal home. Tizard noted that the 1946 Report of the Curtis Committee on the Care of Children Deprived of a Normal Home had set the foundations of the post-war policy for the latter children (HMSO 1946). He applied it as a basis for the care of children at Brooklands (Tizard 1964, Chapter 11). In order to appreciate the significance of this manoeuvre it is necessary to take a brief look at the context and main proposals of this committee. This is

because its underlying principles of care were significantly informed by the mental hygiene movement.

The Curtis Committee was set up by the government in March 1945. There were a number of developments that informed its appointment. In part they relate to a perceived need to fill the gap in proposals for a democratised welfare state, made during the war (Parker 1983). The 1942 Beveridge Report had set out guidelines for a National Health Service and a post-war system of social welfare based on social security, but welfare measures for looked-after children had not been a major concern of this report.

In addition the Committee's formation was prompted by the wartime experience of evacuation. It was here that the mental hygiene movement had a significant impact. The movement was involved in much of the wartime investigation which appeared to show the importance of the family for adequate child development and the prevention of maladjustment. This work also appeared to reveal the inadequacy of much of the institutional provision for looked-after children. With the onset of war three of the mental hygiene movement's core organisations – the Central Association for Mental Welfare, the National Council for Mental Hygiene, and the Child Guidance Council – came together with the Association of Psychiatric Social Workers (APSW) to form a Mental Health Emergency Committee. This organisation soon involved itself in the practicalities and psychological issues of the evacuation. By January 1943, the Emergency Committee had renamed itself the Provisional National Council (PNC) for Mental Health (PNC 1943a).[2] It was this organisation that, after the war, became fully incorporated as the National Association for Mental Health (NAMH).

The Mental Health Emergency Committee set up and developed a nationally co-ordinated system of psychiatric social workers to oversee the psychological and social issues of evacuation. Regional offices were organised in the thirteen civil defence regions, under the control of psychiatric social workers (Central Association for Mental Welfare *et al.*1941; Thomas 1946, p.8). These offices worked closely with government Ministries and local authorities helping to organise and supervise wartime hostels and billets for misplaced children. By the end of the war advice and supervision was being provided for residential homes in existence before the war, as well as day and residential nurseries, and Public Assistance Homes. Two-week training courses were provided for evacuation hostel workers. Conferences were also arranged, on behalf of the Ministry of Health and local authorities, to provide advice and assistance for nursery staff (Thomas 1946, p.8-9; Provisional National Council 1943a, p.11).

On the basis of this activity mental hygienists attempted to set the agenda for child care provision and training. A number of pamphlets were produced during the war aimed at providing advice to workers and public alike on child care, both within the family and in institutions and nurseries (e.g. National Council for Mental Hygiene 1940; Provisional National Council 1944). Pressure for the appointment of a committee to look at care for

[2]It encompassed all the organizations except the APSW. Psychiatric social workers were, however, central to the PNC's evacuation work.

children deprived of a normal home was closely related to this activity. In consequence the mental hygiene movement exerted a powerful influence on the principles of care that the Committee adopted. Two issues in particular that were emphasised by the movement were subsequently adopted by the Curtis Committee for its principles of care. The first was the prioritisation of the home environment, and its emotional atmosphere, for children's successful development, adaptation and mental health. The second was the wartime mental hygiene movement's connection of these principles with a critique of prevailing institutional care.

A 1944 PNC pamphlet, entitled 'The Care of Children Away from their own Homes' announced, for instance, that, 'Family feeling is the basis of society and anything which threatens its strength attacks the structure on which civilisation depends' (PNC 1944, p.2). Adequate relationships within the family allowed the child's 'inner nature' to develop in accordance with its inner emotional needs (PNC 1944, p2-3). The PNC's memorandum of evidence to the Curtis Committee emphasised that the goal of all child care was to enable the child to achieve a healthy maturity. It maintained that *any* upbringing outside the biological family was necessarily handicapping to the child. The aim was therefore, particularly with regard to institutional care, to compensate for the loss of the 'natural' family as far as possible, in order to allow the child to take its place in the community as little handicapped as possible (Thomas 1946, p.12).

The PNC condemned much existing institutional provision for the care of children as detrimental to child development and mental health. It considered that life for children in large groups promoted gross disturbances of development and mental health. Bed-wetting, anti-social behaviour and other emotional disturbances were correlated with large-scale group provision and understood as the precursors of delinquency and mental illness (Thomas 1946). During the war the PNC had developed some of its own experimental ventures. At these a 'Group System' was employed, which it was argued should be employed in all children's institutions. This divided children into small groups of mixed age, sex and temperament. Each group had separate living space for play, meals and sleep. A 'group mother' played a substitute mother role which included organising special outings, clothing and treats. The PNC emphasised that the need for affection, emotional security and appropriate relationships was a psychological need that must be taken account of throughout the whole day (Thomas 1946, p.41). Hospital style regimes were considered over-preoccupied with physical hygiene, cleanliness and efficiency. They were also correlated with an excessive requirement for order and control (Thomas pp.48, 59, 61-2).

The Curtis Committee's principles of care echoed these views. Family-style organisation in small groups was advocated, along with the need for 'house-mothers' providing personal interest and affection for the children (HMSO 1946, para 476-487). The Committee considered much institutional provision to be over-concerned with physical hygiene, cleanliness and efficiency. It noted that standards of physical care, such as food, clothing and accommodation were generally good. But it highlighted that on, what it called, the 'human and emotional side', many children continually felt the lack of affection and personal interest (HMSO 1946, para 427). Curtis emphasised that this lack had been all too obvious to many of the Committee's members when visiting some institutions. At these,

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small children had crowded around the visitor with an ‘almost pathological clamouring for attention and petting’ (HMSO 1946, para 418). Older children showed withdrawn or destructive behaviour and inability to concentrate.

The Curtis Committee thus reiterated the mental hygiene concern with emotionality and family relations. Combined with detailed attention to child care provision outside the family home, it now became a powerful critique of institutional care for children. However, the Curtis Committee also retained something else - the trapdoor of measurements of intellect hidden in this discourse. The Curtis Committee considered the care of children categorised as mentally defective to be outside its remit. It made brief reference to aspects of their care that had come to its attention.

But nevertheless it merely advised that these children should be removed as soon as possible from Public Assistance Institutions and Homes, and placed in appropriate institutions where they could have ‘the kind of care and training they need’ (HMSO 1946, para 509). In addition, even though it considered these children outside its remit, the Committee saw fit to recommend that no administrative changes should be made to their care (HMSO 1946, para 508-510).

Attitudes towards bedwetting illuminate the gulf between approaches advocated for ‘normal’ and ‘difficult’ children in comparison to those who were ‘mentally deficient’. In its memorandum of evidence to the Curtis Committee, the PNC maintained that,

> …the homeless child is particularly susceptible to [bedwetting] because of the emotional deprivations he suffers. … It is often a form of aggressive behaviour – the child’s way of registering protests when conditions make him unhappy. In almost all cases, however, it is a form of behaviour which is beyond the child’s power to control consciously and can be dealt with successfully only where it is possible to get some insight into the deprivations from which he suffers and against which he is unwittingly protesting. Punishment in all cases is liable to exaggerate the difficulty and add other forms of adverse behaviour. (Thomas 1946, p51-2)

These principles were adopted and promoted by the Curtis Committee, but the PNC did not apply them to mentally deficient children. In July 1941 it published in its journal, W. A. G. Francis’ record of enuresis at his evacuated special school for mentally deficient children. Bedwetting, he explained, had quickly become a frequent occurrence at the evacuated school. The method devised for dealing with it was based on praise and punishment. Children who had wet their beds were referred to as ‘offenders’ and sent to the ‘Camp Commandant’ to be recorded and censured. Out of a total of 216 boys living at the camp about 140 boys had appeared on the register. This system, he argued, successfully trained the large majority of children in ‘good personal habits’ (Francis 1941).

If the Curtis Committee merely preserved the trapdoor in care constructed by the theorising of the mental hygiene movement, the Brooklands experiment in effect attempted to seal it up. As we have noted, the thesis of this experiment was that the upbringing of children in mental deficiency institutions should be measured against the accepted principles of care for other children deprived of a normal home.

Tizard had been recruited and encouraged to work on ‘mental deficiency’ by the psychiatrist Aubrey Lewis at the Medical Research Council Social Psychiatry Unit (Clarke and Tizard 1983, p.2-3). From the early 1950s he and fellow psychologist Neil O’Connor carried out influential research. For instance, they published studies showing that the IQ of patients classified as ‘feebleminded’ had been under-estimated by earlier and less sophisticated tests (e.g. Tizard 1950; Tizard and O’Connor 1952). Tizard and O’Connor judged the average IQ of these people at over 70%. They therefore argued that the majority of them should not be considered mentally ‘arrested’ but educationally ‘backward’. Much of this work was carried out at the Fountain mental deficiency hospital in Tooting, London. Under its superintendent, L T Hilliard, the Fountain encouraged associated studies in an endeavour to create a centre of research and professional training. Even here, however, conditions were poor and typical of those in many institutions for mentally handicapped children at the time.

The mental deficiency system had become an ever growing backwater in the decades following the Second World War. From its foundation in 1946, NAMH was well aware of this (e.g. NAMH, 1953, p.5 and 9). Serious issues of insufficient funding, over-crowding, poor staff ratios and poor staff training, along with public apathy, were all noted by NAMH in the 1940s and 50s. However, they did not publicise these deficiencies, preferring instead to work behind the scenes to improve matters. The need for the existing mental deficiency system was never seriously questioned. When the National Council for Civil Liberties embarked on a public campaign against the workings of the system during the 1950s, NAMH dismissed its allegations. The Council attacked wrongful detention along with the coercive and custodial nature of the system in general. NAMH accepted that some reform of legislation and administration was necessary but described the Council’s criticisms as ‘limited and prejudiced’ and maintained that they had ‘distorted the true picture’ (National Association for Mental Health 1951, p.10-11).

Despite the public response of NAMH, the evident poor conditions at the Fountain and other hospitals provided Tizard and his colleagues with the pretext for using the Curtis Report’s recommendations to inform their experiment at Brooklands. At the Fountain, children lived on wards of 60 beds with harassed nurses unable to provide individual attention amidst constant noise. Incontinence was a continual problem and the smell of faeces and urine was often impossible to eradicate. Children were grouped together by sex, age and level of handicap (Tizard 1964, p.79). Tizard noted that the effects of emotional deprivation were clear among the children (Tizard 1964, p.79).

> ‘Rocking and head-banging were commonly observed; they crowded around strangers, clutching and pawing them. The children were apathetic and given to tantrums. They rarely played.

In the same way as the Curtis Committee and wartime mental hygienists had done regarding other children, Tizard used this understanding of emotional needs to condemn institutional provision that was regimented, large-scale and over-concerned with cleanliness and efficiency. This was showed to be destructive, since it was un-related to the emotional requirements of health and development. Discussing the initial problems of settling children in at Brooklands Tizard noted that (Tizard 1964, p.96):

> Not only were they severely subnormal intellectually, but they were institutional children, used to a constant routine and the uniformity of experience of ward life in a hospital. Their lives were, inevitably governed by ward practices, rather than by emotional links with particular adults with whom they identified themselves.

Tizard and his colleagues attributed the children's emotional maladjustment to their life in mental deficiency institutions. They argued that this emotional maladjustment was the most important issue regarding their management, and not their intellectual deficit (Tizard 1964, Part Three).

In keeping with Curtis, the project attempted to create a small 'family style' atmosphere. It provided for a group of children, categorised as 'imbecile', of mixed sex and age ranges between 4 and 10 years. (The children's measured mental ages were given as, half between 3 and 4 years, and a quarter less than 2 years). They were divided into family groups under a housemother. A continuity of close affectionate care by specific adults was aimed for with each child. An emphasis was placed on the children's present emotional needs. This was deliberately in contrast with existing approaches that emphasised training through exercises and drill (Tizard 1964, p.101). The mental hygiene movement had developed a theory of emotionality and mental health that cast the emotional lives of people considered 'mentally deficient' as 'primitive', simple and largely instinctive. Tizard emphasised the children at Brooklands had similar 'intellectual, social and emotional needs' to other children. Indeed their emotional needs were in some ways more complex and therefore required increased understanding (Tizard 1964, p. 60 and 121). Tizard reported that at Brooklands children's emotional maladjustment gradually became considerably lessened, their ability to play, socially and constructively, improved and they developed close attachments to staff and other children. All became more independent in caring for themselves and their ability to use and understand language improved drastically (Tizard 1964, p.130 and 133-4).

The Brooklands study became highly influential in the ensuing decades. Tizard subsequently helped set up the Child Welfare Project, which produced a comparative study of institutional organisation and its effects on care. He also helped set up the Wessex Project, which developed a series of small community residential homes for 'severely mentally handicapped' adults and children (Clarke and Tizard 1983, p. 4.). These, in turn, influenced NAMH (soon to adopt the 'brand name' MIND) and the Government. The 1979 Jay Report on staffing of mental handicap care in the National Health Services and local authorities forcefully advocated 'family-substitute' care for both children and adults (HMSO 1979). MIND hailed its key 'homemaking principle' as central to future community care, and combined this model with an attack on institutionalisation (MIND *c*1979). The latter denoted a style of residential provision that impoverished emotional relationships, mental health and citizenship.

There were notable effects on policy for children's services (e.g. HMSO 1991). But the trapdoor in measurements of intellect appears only partly to have been sealed. For example, the Health Care Commission's 2007 audit of specialist inpatient health care provision for adults and adolescents with learning disabilities found that, 'services are often old fashioned and institutional'. It also doubted the evidence base for psychotropic medication as a

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response to ‘challenging behaviour’ (CHAI 2007, p. 6.). The regular use of drugs to control behaviour is widespread in the care of all people with ‘intellectual disability’ and Deb concurs that the evidence base in generally poor (Deb 2007). At the same time, the long tradition of behavioural interventions for perceived mental health issues is remains prominent (Dagnan 2007, p. 4.).

Meanwhile, in an article written in 2003, Arthur notes that, ‘Numerous authors criticize the almost complete lack of direct psychological attention paid to emotions in people with learning disabilities’ (Arthur 2003, p. 25.). The current article has attempted to show one of the fundamental reasons for this lack. Historically, important elements of psychological theorising have themselves constructed a psychology of deficiency. Intellectual ‘deficiency’ has been used to dismiss the relevance of emotional life and experience. There is a warning in this. Arthur concludes his 2003 article with an extraordinary statement that perhaps unwittingly provides a testament to this legacy:

> There is now sufficient evidence to show that people with learning disabilities have emotional lives with emotional difficulties, need help with these problems and can benefit from psychological techniques (Arthur 2003, p. 29.).

Is it such a ‘discovery’ to find (by 2003) that ‘people with learning disabilities have emotional lives with emotional difficulties’? In their article on the emotional well-being of people with profound and multiple learning disabilities, Sheehy and Nind perhaps offer a timely reminder. When it comes to emotional well-being and mental health, ‘We need to challenge the myth that there is a special knowledge that only specialists have’ (Sheehy and Nind 2005, p. 36.).

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