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Haggett A. *A History of Male Psychological Disorders in Britain, 1945–1980*. Basingstoke (UK): Palgrave Macmillan; 2015.

Chapter 4 Pharmacological Solutions

Introduction

In a lengthy and well-cited article published in the *Journal of the Royal College of General Practitioners* in 1971, Peter Parish, physician and medical sociologist at University College Swansea, stated that as a result of advances in psychopharmacology and the influences of advertising, ‘large sections both of the medical profession and the general public have come to regard psychotropic drugs as a universal panacea for a wide range of social and emotional problems’.¹ The resulting cost to the NHS was considerable. As Parish pointed out, between 1965 and 1970, 47.2 million psychotropic drug prescriptions were dispensed under the National Health Service (NHS), costing a sizeable £21.5 million.² The soaring cost of psychotropic drugs prompted much debate in the medical press about their use and efficacy. Interest was particularly focused on prescribing patterns between individual doctors and between practices across the country – and on how doctors gained information about indications for different drugs. Additionally, there were heated debates about the efficacy of different groups of drugs. Although there was much confusion and disagreement on these topics, research articles nonetheless reflected one consistent finding: at least twice as many prescriptions for psychotropic drugs were issued to women than to men. From mid-century, on both sides of the Atlantic, scholars and clinicians have attempted to account for this difference. Some have argued that, from the 1950s there has been an epidemic of psychological illness in women. Others maintain that women are simply more likely to seek medical advice and that doctors have tended to ‘code’ psychological disorders as female problems.³ The purpose of this chapter is to consider a range of complex factors that lie beneath prescribing statistics. Analysis of published research on the topic, combined with the recollections of retired doctors, suggests that there are many reasons why women were prescribed drugs more frequently and that official data on prescribing obscures a more complicated picture. Mental ‘distress’ in men was more common than has been previously acknowledged and was treated in different ways, often with alternative drugs and with self-medication with over-the-counter remedies.

Psychotropic drugs from the 1950s

The post-war period was central to developments in the pharmacological treatment of mental illness and much has been written about the evolution of new treatments from the 1950s. Numerous historians of psychiatry, pharmacology and mental illness have published accounts of their emergence. It is not the remit of this chapter to repeat such histories in detail; however, certain aspects of these developments deserve highlighting. During the period covered by this book, the chemotherapeutic treatment of anxiety disorders, for example, changed significantly with the shift in popularity from old-style hypnotic sedative drugs to the newer tranquillising agents during the 1960s. As has been pointed out already, during the period, depression was also more commonly identified as a condition in its own right, treated specifically with new antidepressants. This chapter will explore debates about the use of these drugs and examine prescribing patterns between doctors.

As is well known, the late 1950s were characterised by cautious optimism surrounding the discovery of the therapeutic effects of the major tranquilliser, chlorpromazine, for the treatment of serious psychosis.⁴ David Healy cautions that histories of chlorpromazine have been too narrowly focused on whether or not the drug was responsible for the closure of asylums. He argues that what was equally significant was that by reducing the numbers of patients with serious symptomatic psychosis, less severe symptoms of neurosis and depression duly emerged at the forefront of psychiatric practice.⁵ Indeed, chlorpromazine was followed closely by the first compound of a group of drugs that were to become known as the ‘minor’ tranquillisers for the treatment of anxiety disorders. Meprobamate, sold in the United States under the trademark as Miltown, and in Britain as Equanil, became the best-known drug of its kind until the discovery of chlordiazepoxide (Librium), the first of the benzodiazepine tranquillisers.⁶ Diazepam, the second of the benzodiazepines, was introduced in 1963 and its trade name Valium came to be used almost generically to mean ‘tranquilliser’.⁷ Commentators soon suggested that the calming effects of the benzodiazepines were ‘unique’ and even ‘remarkable’, and studies showed that they were much safer in overdose than existing hypnotic sedative preparations.⁸ However, concerns were soon raised about the potential for dependence and indeed, by the 1970s, it emerged that large numbers of people were addicted to benzodiazepines.⁹

Increasingly, optimism surrounded the pharmacological treatment of both endogenous and reactive depressions. A group of drugs known as the tricyclics proved promising in the treatment of classic endogenous depression, whereas

'atypical' or reactive depressions appeared to react favourably to monoamine oxidase inhibitors (MAOIs), particularly where symptoms of depression were aggravated by anxiety. In many cases, patients were prescribed both an antidepressant and a benzodiazepine. As Callahan and Berrios have noted, psychotherapeutic, or 'talking' methods of treatment for minor mental illness proved impractical in a primary care setting.¹⁰ As the oral testimonies in this book from physicians suggest, doctors were faced with short consultation times, large lists of patients and minimal ancillary support. The pharmacological treatment of depression and anxiety therefore became entrenched during this period.

It is important to remember that, although the new drugs expanded the pharmacological options available to physicians, the use of prescribed psychoactive substances has a much longer history. Many of the older drugs, such as amphetamines and barbiturate sedatives, continued to be prescribed alongside the newer ones. Some of them were also used in combination preparations alongside other compounds for the treatment of a wide range of psychological and physical complaints ranging from appetite suppressants to treatments for gastric discomfort. By the time of Parish's seminal study of psycho-pharmaceutical prescribing published in 1971, the benzodiazepines, tricyclics and MAOIs were the drugs of choice; however, significant numbers of prescriptions for phenobarbitone and sodium amylal (barbiturates) were still being administered (see Table 4.1).

Between 1965 and 1970, the prescribing of all tranquillising drugs increased from 10.8 million prescriptions to 17.2 million. This rise was largely due to a 110 per cent increase in prescriptions for the minor tranquillisers. During this five-year period, for example, the annual prescribing of Librium increased by 1.15 million and Valium by 4.1 million. Parish noted that such a significant rise could not be accounted for by the concomitant decrease in the use of the older-style sedatives, which had declined only moderately.¹¹ The period also saw a considerable rise in the use of non-barbiturate hypnotics, particularly the drugs Mandrax and Mogodon that were prescribed for sedation and insomnia.¹² Antidepressant prescribing increased consistently during the five-year period; however, a pronounced rise in the use of antidepressants did not occur until later in the 1970s and into the 1980s.

From the records of forty-eight GPs examined in Parish's study, 17.1 per cent of prescriptions were for women and 8 per cent were for men.¹³ For women, the trend showed a progressive increase in prescriptions up to the age of forty-five. After this age, numbers decreased until the age of seventy when they rose sharply again. Trends in prescribing to men illustrated a more steady, but moderate increase throughout their lifetime.¹⁴ The male to female ratio remained relatively consistent between doctors and between practices (see Table 4.2), but there were inter-practice variations in the overall percentage of patients prescribed psychotropic drugs and large differences in the use of different psychotherapeutic groups.¹⁵ Some physicians preferred to use tranquillising drugs; others opted more commonly for antidepressants. One doctor, for example, used none of the popular psychotropic drugs, and gave most of his patients 'Beplete Syrup' (a vitamin and barbiturate combination). These differences led Parish to caution that reports of overall prescribing were therefore of rather limited value.¹⁶ Stimulants and appetite suppressants were in all cases much more frequently prescribed to women, usually for weight loss, although overall prescribing of amphetamines decreased through the period due to increasing concerns about tolerance and addiction.¹⁷ Parish's study reflected the findings of research undertaken during the previous decade that revealed large variations in prescribing patterns between doctors. A study of prescribing patterns in three northern towns, for instance, also illustrated that 'not only the choice of individual remedies but also the proportion of remedies in different therapeutic groups show much difference between individuals, as do the rates per thousand patients on the doctor's lists'.¹⁸ Ultimately, such studies raised many questions about the true extent of psychiatric morbidity but provided few answers. As Parish noted at the end of his discussion, the results of his study had highlighted some interesting problems that required further research. First and foremost of these, he asked, was the question: 'Why are twice as many women as men prescribed psychotropic drugs?'¹⁹

Behind the data: a complex picture

There are a number of reasons why it was impossible to determine the true extent of psychiatric morbidity in the community, or draw conclusions about the gendered distribution of illness, based on prescribing data. First of all, from the 1960s, doctors were ill-prepared for the sudden increase in therapeutic preparations. Doctors entering practice in the late 1950s and early 1960s had few pharmacological choices available to them. General practitioners recalled that, until the mid-1960s, they primarily used a range of 'tonics' that were dispensed in a variety of colours and available in different strengths. Giles Walden, upon arriving at his first post in 1963, found that the three existing doctors dispensed two types of tonics – one that was dark brown, the other light brown: 'What was in it, I just don't know, but I mean that was their armament really, barbiturates and these tonics with a bit of strychnine in, you know.'²⁰ Among the medical profession, the term 'tonic' in this period indicated a preparation with muscle-building or 'toning'

properties, often containing strychnine; however, the word was used more loosely by the public who perceived tonics to improve health more generally or to remedy some kind of ‘deficiency’.²¹ Christian Edwards remembered prescribing tablets he described as ‘pink, blue and white aspirins’, and added that ‘the pink worked much better than the blue and not as good as the white, or something’.²² Richard Stanton, who, after qualifying, fulfilled a number of locum posts, said that he would never forget what he encountered in one doctor’s consulting room:

On this guy’s desk-blotter, he had written about twenty drugs around the edge, and that was his whole pharmacy. That was all he ever gave out. I asked one of the partners, ‘What’s this all about?’ He said, ‘That’s all he ever uses, those twenty drugs.’²³

A number of doctors pointed out that tonic preparations often acted as a kind of placebo and that in some respects the demand for them was patient-led. Stanton recalled:

They might actually come in and one of the words that people used was ‘Doctor, I think I need a tonic . . .’ which of course was put into their minds, because doctors prescribed a tonic. ‘Let’s go down [to] the doctor and get a tonic, then I’ll feel better’. So we responded to that. I mean that, that was the traditional approach.²⁴

Giles Walden described a very similar situation:

All they wanted was their bottle of the usual red stuff, or green stuff [laughing] – or even the blue medicine. ‘That’s all I want Doc’ – you know. And this used to be prescribed and off they went. And to begin with there was little emphasis on trying to find out what it was for or why they needed it. I sort of found myself having to go along with this to begin with . . . but I soon began to question what it was that we were dishing out, and for me, things began to change.²⁵

As new drugs for anxiety and depression were developed, the range of treatments became increasingly sophisticated and general practitioners (GPs) were largely required to do their own research into the pharmacological properties of the various groups of drugs. A quick glance at the pharmaceutical reference book, the *British National Formulary (BNF)*, used widely by GPs, illustrates the marked increase in preparations between the early 1950s and the 1970s. The only drugs listed for psychological disorders and insomnia in the 1952 edition were categorised under the heading, ‘Drugs acting on the central nervous system’. These included barbiturates, potassium bromide, amphetamines, analgesics and anaesthetics.²⁶ Other drugs noted to be of use in stimulating appetite, and as acting in part ‘through psychological mechanisms’, were listed under the heading ‘Bitters and tonics’. Preparations included strychnine and iron, gentian with alkali or acid, and Nux Vomica with alkali. These mixtures have a long history of medicinal use in tonic preparations – strychnine, for example, in non-toxic doses was regarded as a stimulant and often used for respiratory and cardiac conditions.²⁷ By 1957, the major anti-psychotics, chlorpromazine and reserpine, were added to the list of drugs acting on the central nervous system, and in 1960, a new category of ‘sedatives and tranquillisers’ appeared. By 1960, there were new warnings about drug dependence and a dedicated section of the reference book entitled, ‘Habit-forming drugs’ (largely composed of hypnotics, sedatives and analgesics).²⁸ In 1963, the catalogue of entries expanded extensively to include the new benzodiazepine, Librium; the tricyclic antidepressant, imipramine; a range of MAOI antidepressants; and the minor tranquilliser, meprobamate.²⁹ Although a new distinct category of ‘Antidepressants’ appears in 1963, the broad format of the publication remained the same. The new drugs were simply listed in the front section as ‘additions’, with no detailed discussion about individual preparations. In less than ten years, thus, the pharmacological options available to physicians expanded considerably – yet data on their efficacy was to be hotly debated, and at times disputed, for many years to come. The *BNF* did not change its format significantly until 1974, when the publication split into two separate sections: the first, entitled ‘Notes on drugs’, provided detailed information and discussion about drugs under specific pharmacological classifications; the second provided a summary of preparations with specifications regarding dosage and contraindications to their use. It is notable that, by the 1974 edition, all reference to the psychological component of tonic preparations disappears altogether as the category of ‘Bitters and tonics’ disappears, to be replaced with the heading ‘Nutrition and blood’ – perhaps a discernible marker of the increasing shift towards a reductionist medical model of mental illness.

Given the considerable expansion in available treatments for psychological symptoms, general practitioners were provided with a limited range of methods for keeping abreast of new drugs. Many of them turned to pharmaceutical

prescribing reference publications such as the *BNF* and the *Monthly Index of Medical Specialities*, referred to as *MIMS*. Some asked for advice from local hospital consultants in an attempt to gain specialist knowledge, and others conferred with their colleagues in primary care. GPs recalled that, during these years, the *BMJ* and the *Lancet* published very little on psycho-pharmaceuticals that might assist doctors with the day-to-day realities of prescribing.³⁰ At the centre of debates on sources of therapeutic information was the concern that undergraduate medical training focused primarily on the basic medical sciences and less on pharmacology. During preregistration training and thereafter, the acquisition of knowledge in this area was primarily the responsibility of the individual doctor.³¹ One research article noted specifically that the rapid advances in pharmacology had made a very large number of compounds available for medical treatment, but that there was ‘no necessity for a doctor to acquaint himself with any information about these new compounds. If he does attempt to do so, where and how he does this is wholly his own decision’.³² The study, which included a sample of prescribing over one week by a group of GPs in Liverpool, indicated that when treating serious physical disease, general practitioners were more inclined to rely on their former clinical training. This was predominantly the case for heart disease, for example, with advice from consultant cardiologists where necessary. In contrast, when presented with psychological disorders, peptic ulcer and dyspepsia, doctors were more likely to consult handbooks such as the *BNF* – and take advice from pharmaceutical representatives.³³ The study suggested that British doctors, particularly older doctors, depended on information from drug companies where advances in therapeutics had occurred since their medical training had ceased.³⁴ Dunnell and Cartwright’s study, *Medicine Takers, Prescribers and Hoarders*, published in 1972, reflected these findings, suggesting that one of the most important sources of information about new drugs was the literature produced by drug firms. In this research, 45 per cent of doctors questioned had seen five or more drug-firm representatives in the previous four weeks and only 6 per cent had not seen any.³⁵

The growing range of drugs available, the lack of training, the proliferation of advertising and the concurrent increase in prescribing, caused considerable concern and attracted criticism in the medical press. This was summarised opportunely by Derrick Dunlop, Chair of Therapeutics and Clinical Pharmacology at Edinburgh University, who noted: ‘Nowadays, when we are Jove-like in the therapeutic thunderbolts we hurl – drugs potent for evil as well as for good – it is of paramount importance for us to be thoroughly conversant with the pharmacological tools of our trade.’³⁶ Parish, in his comprehensive study of pharmaceutical prescribing, raised specific concerns about the sources of information available to general practitioners, warning that:

It is difficult to see how the general practitioner can have access to concise and unbiased information and how he has time to sift out objective data, which he needs if he has to make rational therapeutic decisions. Huge sums of money are spent annually to advertise drugs to prescribers, and the prescribing patterns and rates of general practitioners indicate how effective these promotional efforts are.³⁷

In May 1965, the Ministry of Health set up a Committee of Enquiry into the Relationship between the Pharmaceutical Industry and the NHS, under the Chairmanship of Lord Sainsbury. In its conclusion, the committee confirmed many of the concerns articulated in the medical press, which stated that some of the sales material produced by pharmaceutical manufacturers failed to measure up to the required standards in informing doctors adequately about new (and existing) preparations.³⁸ Parish was critical that the claims made by manufacturers placed significant pressure on general practitioners because, with ‘such a torrent of information pouring on to him, [he] can cope only by having details of a particular drug and its effects brought clearly to his notice’.³⁹ Ultimately, Parish maintained that responsible and appropriate prescribing⁴⁰ could only be promoted by a system of continuous therapeutic education at undergraduate and postgraduate level.

The influence of pharmaceutical advertising on doctors ultimately contributed to the eclipse of male psychological illness. Manufacturers reinforced and exploited stereotypical gender roles in their marketing material, prompting doctors to prescribe drugs from within a traditional framework that assumed women were more commonly affected by mental disorders. Additionally, drug firms produced combination preparations that were less obviously ‘psychotropic’ in their action because their primary agent was designed to treat an organic condition, such as peptic ulcer or appetite loss. Many of these drugs were not classed as ‘psychotropic’, yet they often contained psychoactive compounds – which might either sedate or stimulate.

Studies on psycho-pharmaceutical prescribing during this period were undertaken within the framework of the WHO’s classification of psychotropic drugs. The operational definitions were divided into five groups: neuroleptics (major tranquillisers); anxiolytic sedatives (minor tranquillisers); antidepressants (tricyclics and MAOIs);

psychostimulants (amphetamines); and psychodysleptics (hallucinogens).⁴¹ A number of other drugs were also being investigated at this time, among them being lithium for use in what was then known as manic-depressive disorder, and methadone for use in the treatment of narcotic addiction. However, preparations for other physical conditions that combined two compounds, one of which was a psychotropic drug, were invariably excluded from the WHO classification framework and subsequently from studies on psycho-pharmaceutical prescribing trends. Parish, for example, stated clearly at the beginning of his study that, ‘admixtures’ in which the psychotropic drug was not the main constituent were excluded.⁴² In broader studies of prescribing trends, combination drugs most usually fell under the classification ‘drugs acting on the digestive system’ or under the ill-defined category, ‘others’.⁴³ The most commonly prescribed admixtures were those used to treat gastric discomfort from peptic ulcer or indigestion and were, as such, most commonly prescribed to men. They usually contained a compound to reduce stomach acid and a tranquillising agent to reduce anxiety, which, as this book has suggested was strongly associated with peptic ulcer during the period. The manufacturers Roche, for example, widely marketed a drug called Libraxin during the late 1960s and 1970s, which contained the benzodiazepine Librium and clidinium bromide, a compound that reduces stomach cramping and acid production. The company claimed that ‘By reducing anxiety and aggression, and by its anticholinergic activity, Libraxin blocks reactions which increase gastric secretions and inflame gastric mucosa.’ In fact, claimed Roche: ‘Libraxin usefully calms both the stomach and the patient’.⁴⁴ The drug, Nactisol, produced by Beecham Laboratories, acted in a similar fashion, containing a compound for ulcer management combined with a barbiturate sedative for cases ‘where anxiety complicates ulcer management’.⁴⁵ Stelabid, promoted widely during the 1960s by Smith Kline and French, claimed to ‘settle the matter’ in a ‘wide range of gastro-intestinal disorders’. This drug contained an anti-spasmodic with an anti-psychotic compound, and the marketing material claimed that it ‘exerts a beneficent calming action which effectively allays the background stress and worry that so often provoke or aggravate such conditions’.⁴⁶ Another widely promoted admixture was the drug, Durophet M, which was a⁴⁷ sedative/stimulant combination, used to aid the ‘psychological difficulties of dietary restriction’ in obesity.

It is difficult to say precisely how widely GPs prescribed these drugs. The position held by editors of the *BNF* on their efficacy was definitively negative, and it is noted in the 1974–6 edition that, compared to other publications from the industry, there were fewer compound preparations discussed in the handbook. Describing them as ‘a relic of the whimsical mixtures of our predecessors’, the editors were of ‘the austere view that such preparations pander to bad practice’, and it was recommended instead that, ‘each drug should be given in its optimum dosage, which is not possible in a fixed combination’.⁴⁸ The same message was reiterated in the subsequent issue (1976–8) under the section on drugs that act on the alimentary system, where the advice was unequivocally that combination drugs should be avoided.⁴⁹ This position was supported by a number of doctors during interview where the criticism laid against combination preparations was that if the patient improved following the administering of the drug, it was not possible to tell which compound had produced improvement. Christian Edwards, for example, stated that he was ‘brought up on single-drug prescribing’ and avoided combinations – ‘tempting though it was’. His concern was about side-effects and he put forward an analogy to describe the potential problems: ‘It’s like riding two bicycles at the same time, you don’t know which one to brake on.’⁵⁰ Another doctor recalled that the drugs were ‘very heavily advertised’ but that he had not prescribed them because they ‘clashed’ with his attitude to medicine, noting that, ‘If the patient got better, you had no clue which bit of it was helping.’⁵¹ In contrast, other doctors used them routinely and spoke favourably about the broad concept. Glen Haden maintained that the combination drugs for stomach disorders were ‘very effective’, and he recalled that he used to prescribe Libraxin in ‘vast quantities’.⁵² Rupert Espley confirmed that during his early years in practice, the convention of ‘putting a little bit of sedative into things’ was relatively widespread, and, laughing, he recalled one dispensing surgery where colleagues would ‘put a little bit of phenobarbital in the bottle of medicine, according to the amount they felt was needed’. When asked to clarify to which medicines this might apply, Dr Espley replied, ‘Oh, in a bottle of medicine for magnesium trisilicate for dyspepsia or something like that.’⁵³ Undoubtedly, some in the medical community frowned upon the use of combination drugs; nevertheless, the proliferation of adverts for such preparations does suggest that a considerable market existed for those who favoured the approach. As Roger Lea (a West Country GP) observed, the pharmaceutical companies collated large amounts of data on prescribing trends. He eventually refused to meet with drug representatives, because ‘they would come in with a headful of data about my prescribing habits, and what I did – you know – how to make me feel good ... I reckoned they were too good at it.’⁵⁴

Since research suggested older GPs were more likely to rely on information from drug companies, it would be reasonable to suggest that these drugs were probably prescribed in significant numbers, and most commonly to men, where anxiety featured as an aspect of some physical disorder. Yet official data on the prescribing of psychotropic drugs did not reflect the use of these preparations and continued to provide compelling evidence that women

consumed significantly greater amounts of drugs in all psychotropic categories. In the late 1970s, the Canadian researcher Ruth Cooperstock, who published widely on gender and psychotropic drug use, suggested that the use of these compounds was being underestimated in data; however, little attention was paid to the topic in Britain. Cooperstock claimed that, in Canada, the use of mixed drugs had expanded throughout the 1970s ‘to include all varieties of somatic disorders and their emotional sequelae’.⁵⁵ Using the drug, Stelabid, as an example, she observed that:

In 1973, there were as many prescriptions for Stelabid, a mixed psychotropic, as for Stelazine, the pure tranquilizer. Stelabid, however, is termed an antispasmodic drug and is never identified as a psychotropic, consequently deflating the actual proportion consumed.⁵⁶

A year later, in a sociological study of gender-role conflict and benzodiazepine use, Cooperstock maintained that male use of tranquillising agents tended to be related to conflict regarding work performance, ‘or more typically, the need to contain somatic symptoms in order to perform an occupational role’. She argued that men in her study were less emotionally expressive than women, ‘a consequence of which appeared to be greater emphasis on reports of somatic problems’.⁵⁷

Self-medication

Parish’s study of pharmaceutical prescribing patterns revealed that not only had the taking of prescribed medicines increased, but the use of non-prescribed or so-called ‘over-the-counter’ drugs had also increased dramatically. In 1968, £80 million of non-prescribed medicines were purchased.⁵⁸ He pointed out that since only one-third of illness episodes were presented to the general practitioner, it would appear that the practice of self-medication was not influenced by doctors’ attitudes and concepts. Dunnell and Cartwright’s extensive study of medicine-taking revealed that, of those interviewed, three-quarters of the women and three-fifths of the men had taken some self-prescribed medicine in the past two weeks.⁵⁹ The authors emphasised that higher numbers of women taking over-the-counter medicines might be accounted for by the fact that women generally took responsibility for the family shopping and were therefore the ones exposed to persuasive advertising for remedies in shops. They further cautioned that reported behaviour was not necessarily actual behaviour and evidence from the previous chapters in this book suggests that men might well have been reluctant to admit taking remedies for ailments.⁶⁰ The figures for non-prescribed medication certainly led Dunnell and Cartwright to conclude that a large ‘iceberg’ of illness existed in the community at any one time that was not known to the medical profession.⁶¹

A survey of advertising for home remedies throughout the 1950s and 1960s certainly suggests that there was a sizeable market for medicines and tonics that claimed to relieve stress, and symptoms of indigestion and other digestive disorders. Prior to the 1950s, pharmaceutical companies exploited the wartime market, both in Britain and abroad, expounding the positive effects of tonics to markets in West Africa and Burma, for treatment post-malaria and other tropical illnesses.⁶² Adverts were framed within stereotypical gender roles. Sanatogen tonic, for example, was targeted at women for promoting and maintaining beauty. One advert claimed: ‘The bloom of youth often leaves a woman early through fevers and the weakening influence of the climate.’ Another reminded audiences that: ‘A healthy youthful wife is a joy to her husband.’ The makers of the tonic also claimed that it would ‘banish weakness’ and ‘restore health’ in men.⁶³ At home, the makers of Rennie’s indigestion tablets used images of military personnel in their adverts, which appeared regularly in national newspapers. They claimed that ‘war-time indigestion’ was caused by ‘worry, suspense and hurried meals’. ‘A couple of Rennie’s’ would help ‘stomach pains to stop naturally’.⁶⁴ Other adverts drew upon images of suited businessmen and the notion of acid stomach caused by stress at work. One alarming advert released in national newspapers featured a picture of a large burned carpet, accompanied by the text: ‘The acid in your stomach would burn a hole in a carpet.’ The notion that men should ‘stand up’ to their indigestion was implicit in all adverts and demonstrated in a promotional piece for Rennie’s, which depicted a hard-working warden, looking for ‘easy instant relief’, whose ‘job was tough, but his indigestion was tougher’.⁶⁵ Another image prompted men not to become ‘indigestion martyrs’.⁶⁶ War workers, business executives and working class men all appeared in adverts for the same products, but could be distinguished by their dress: military uniform, suits and hard hats or flat cloth caps respectively. Women appeared occasionally in images during the war years, referring to traumatic circumstances such as air raids and appearing in images of factory work, where time pressures and unappetising meals were seen to cause a problem with digestion. However, during the war, the images were predominantly of men.

Post-war, manufacturers of tonics and indigestion remedies employed a range of strategies to engage with the male market. Arguably, the theme of defeating weakness and regaining strength was the most common way in which advertisers resonated with the beliefs and values associated with contemporary masculinity. Socialisation into the male role began early, evident in marketing images that depicted small children, such as the advert for Horlicks shown in [Figure 4.1](#).

In this instance, the manufacturers claim explicitly that ‘Little boys are made of GOOD STRONG BONES, good tough muscle, and of loving care’. A mother’s loving care therefore required that she provide her sons with the correct nutrition so that they may ‘build their bodies into that strength on which health and happiness depend. Setting already the wise habit of a lifetime’.

As numerous authors have noted, advertisements are one of the most important cultural factors reflecting, moulding (and remoulding) everyday life.⁶⁶ Although, from this study it is not possible to measure their influence, the motivational psychology behind such adverts is clear from archival collections of draft drawings and copy text filed in advertising agencies’ guard books. [Figures 4.2](#) and [4.3](#), for example, are images in the early stages of design for the product Iron Jelloids, which was a tonic preparation sold widely during the 1950s.

As [Figure 4.2](#) suggests, this product claimed essentially to do two different things. Where a woman is pictured, the advert suggests that Iron Jelloids might make her look ‘lovelier every day’, in contrast to the image of a man seen participating in a tug of war, where it is intimated that the product might make men ‘feel stronger every day in every way’. For the suited gentleman who featured in the guard book image in [Figure 4.3](#), Iron Jelloids appear to transform the man’s sullen, grey complexion, from ‘Weakness’ to ‘A1’ condition, the metamorphosis duly represented by a much brighter, healthier and stronger looking appearance.

Advertisers increasingly began to draw on well-known figures and television personalities to endorse their products. The makers of Macleans indigestion tablets employed the television host, Gilbert Harding, to advertise their product in 1959. During the 1950s, Harding hosted the BBC Radio show, *I Beg to Differ*, and became infamous for his abrupt, outspoken and sometimes rude behaviour. He went on to feature as a regular panellist on the BBC light-entertainment programme, *What’s my Line?* Harding’s brusque and direct approach was applied skilfully in marketing Macleans Tablets, where he appeared to be expressing his frustration with ‘people who just don’t bother to think for themselves’ and who ‘never stop complaining’. For indigestion sufferers, according to Harding, there was simply no excuse for complaining, or for ‘suffering’ from pain – Macleans Tablets were the obvious answer. Harding claimed to always carry some in his pocket and suggested that ‘anyone with any sense’ should do the same (See [Figure 4.4](#)).⁶⁷

Although the majority of advertisements directed at men harmonised with the theme of restoring physical strength, vitality and vigour, manufacturers increasingly indicated that men were also vulnerable to psychological stress. Drawing on contemporary scientific studies of stress, and on broader cultural anxieties about the negative health consequences of modern living, the makers of the tonic, Phosferine, produced numerous adverts depicting men with what they described as ‘nervous exhaustion’. The testimonial featured in the advert for Phosferine in [Figure 4.5](#) indeed states explicitly that nerve trouble, for this particular gentleman, caused him to fear train and bus journeys. The cause of ‘stress’ nonetheless, in this case, was located in the ‘gastric nerves’, causing loss of appetite and lack of sleep. This was in contrast to the claims increasingly put forward by pharmaceutical companies for prescribed psychotropic drugs, which claimed to act directly on chemicals in the brain and not the nervous system.⁶⁸

Advertisements for over-the-counter preparations also reflected the social changes that took place from the end of the Second World War. Although most women, certainly through the 1950s and into the 1960s, still fulfilled their primary role at home as wives and mothers, men had begun to increase their engagement with family and domestic life. A series of fictional, drama-style advertisements for Horlicks mirrored the developments in gender roles, featuring men in roles as husbands and fathers. The male protagonist in these adverts would invariably be ‘grumpy’ and exhausted, often upsetting his wife and children. In one advert, published widely in the national press during the mid-1950s, a father is pictured rejecting a hand-made wooden gift from his son, irritated by the noise the boy had created when constructing it. Another scene depicted a policeman whose tiredness had caused him to neglect his son, resulting in delinquent behaviour. Both examples reflect the increasing social and cultural importance of the male role in the home and at the centre of the family. In all cases nonetheless, male protagonists needed prompting by their wives to seek help from the doctor, who invariably confirmed that drinking Horlicks at night might aid sleep and relaxation. Miraculous transformations to mood and manner ensued. The makers of Horlicks also utilised the charms of the well-known actor, novelist and columnist, Godfrey Winn, in a ‘problem page’ style advert during the late 1950s. Winn was known for his popularity with a female audience and regularly contributed to the BBC Radio show, *Housewives’*

Choice. An advert for Horlicks in 1957 featured a letter from a gentleman seeking Winn's advice about insomnia. Not only was the complainant 'miserable' himself, but he confessed that he 'made the whole family the same – especially [his] wife who became a bundle of nerves and had to seek medical aid'. It is likely such letters were entirely fictitious; however, it is interesting that this scenario echoed the accounts put forward by many family doctors who maintained that women often sought medical help for stress and nerves caused by living with a family member with psychological problems. At the end of Winn's advice page, he cautioned against 'taking sleeping pills', reassuring readers that his 'Horlicks postbag' was full of similar cases – yet taking Horlicks would undoubtedly ensure that life would become a 'better and happier thing'.⁶⁹

The manufacturers of indigestion remedies either drew an association with poor diet and irregular meals and dyspepsia, or, as was the case with Maclean's Tablets and Rennies, increasingly they claimed a link between worry and indigestion. In Rennies' adverts, the tagline: 'Dyspepsia – sometimes started by worry, invariably stopped by Rennies' appeared often.⁷⁰ One promotional advert released by the same company and published in the *Daily Mail* and the *Daily Express* claimed to carry a medical seal of approval and featured a cartoon image of a doctor with a stethoscope around his neck, who had ostensibly 'cured his own stomach trouble after hospital treatment failed'. Worried and overworked, dealing with a large list of patients and struck down with gastric symptoms, the 'doctor' (whose name was omitted) claimed that gastric pain, heartburn and acidity 'disappeared in a matter of seconds after taking a couple of [Rennies]'. Promoting the 'unusual medicinal qualities' of Rennies tablets, the manufacturers claimed that in addition to this doctor, 1,193 other doctors had also written to say they were prescribing the tablets for their patients as the most effective treatment.⁷¹

Although it is not possible to quantify with any accuracy the extent to which men were purchasing home remedies for minor ailments, the widespread and consistent advertising of such products suggests that a strong and viable market existed. Accounts from doctors certainly suggest that men were more comfortable treating minor ailments themselves than attending the doctor's surgery, and as we have seen, women played a central role in persuading men to seek medical help and in stocking the medicine cabinet as part of the weekly family shop. Over-the-counter remedies certainly afforded men the opportunity to treat conditions themselves and manufacturers often exploited the idea that they were reluctant to seek medical help. An advert for a product called Hemotabs, indicated for use in the treatment of haemorrhoids, provides a typical example. Depicting an image of a male, the makers noted that 'after years of suffering in silence', the product would bring relief.⁷²

Reflections

Parish observed in his study during the early 1970s that research on the topic of psycho-pharmaceutical prescribing had been unable to produce 'any firm conclusions'. Results, he pointed out:

. . . depend upon the size of the sample, the diagnostic classifications, the indices of morbidity, the system of sampling, the methods of recording data, and above all, upon the attitudes towards mental illness of the researchers and the general practitioners being investigated.⁷³

Until the development of computerised records, not all doctors kept accurate records of prescribing data.⁷⁴ Studies were therefore reliant upon those who kept records and were willing to submit them for research. Such doctors were a self-selected group and we know very little about the prescribing habits of those doctors who did not keep accurate records. Reports of mental illness were also only based upon patients who attended their GPs. As Parish pointed out, these too were 'a self-selected group of persons whose attitudes and expectations may differ from those who do not attend and yet suffer from symptoms'.⁷⁵ In his report, Parish neatly summarised many of the methodological obstacles faced in previous research:

In the past, many of these survey findings have not been corrected for age and sex differences, and the period of the surveys has varied from anywhere between one week and five years. It is also obvious that the parameters on which reports of mental disorders in general practice are based need challenging, particularly the present definitions of what is abnormal and what is normal mental health . . . When does a 'person' become 'a patient'? Where is the cut-off point in deciding whether a person is 'neurotic'? . . . Further, there is little doubt that the estimated extent of 'mental illness' is higher when assessed in the community than when assessed from general practitioners' consulting rooms, and this difference can only be explained by differences in attitude towards mental illness and towards general practitioners.⁷⁶

Research published during the early 1980s began to consider some of these factors in more detail and to reflect on the influence of gender stereotyping upon prescribing. In a longitudinal study of psychotropic drug prescriptions undertaken at the General Practice Research Unit, Institute of Psychiatry in London, doctors were asked to record the complaints presented to them by patients at the initial consultation. The study found that a much greater proportion of women ‘described’ classical symptoms of depression, whereas a larger proportion of men complained not of depression, but of other physical symptoms – and frequently of sleep disturbance.⁷⁷ The study also revealed that more women than men received a tranquilliser for depression (in addition to, or in place of an antidepressant). The researchers were unable to explain why this might be and subsequently urged that this be explored more fully in future research.⁷⁸ Commentators began to suggest that psychotropic drugs, and tranquillisers in particular, were being prescribed to remedy symptoms caused by social and not medical problems. As Kevin Koumjian noted in the early 1980s, social problems related to family, work and other spheres of social life were increasingly being defined as medical problems – for which a medical solution could be sought.⁷⁹ Sociological, psychological and political interest focused on this topic, in part prompted by claims put forward by the feminist movement that suggested the limited opportunities afforded to women were stifling and oppressive, causing them to experience depression and anxiety.⁸⁰ Historians of medicine now debate the extent to which this was in fact the case. However, a point made less frequently was that women were certainly more at ease articulating social problems to their doctor and would seek help and advice in situations where men were more reticent. Much of the research undertaken on both sides of the Atlantic from the late 1970s suggests that women were more comfortable confiding in doctors about strains in family groups, marital difficulties and the pressures of raising children.⁸¹ The increasing medicalisation of daily problems meant that it was therefore almost inevitable that more women would be prescribed psychotropic drugs. Research undertaken by Joanna Murray, again from the General Practice Research Institute, revealed that women on long-term drugs felt that they required medication for a wide range of daily functions, including: travelling, shopping, mixing with people and running their homes.⁸² The more intensely commentators focused on women’s consumption of psychotropic drugs, the less likely it was that the spotlight might shine on presentations of male distress and the reasons why men were prescribed drugs less frequently.

As the other chapters in this book have shown, there is some evidence that doctors’ views about the gendered distribution of mental illness influenced consultations with their patients and subsequent prescribing habits.⁸³ The view that women were hormonally predisposed to psychiatric symptoms, for example, remained prevalent throughout the 1960s and 1970s – a point that featured in many of my interviews with doctors. Parish too, noted in his study, that disorders of menstruation and the menopause were common physical disorders for which psychotropic drugs were prescribed – in particular the minor tranquillisers, Librium and Valium. According to his research, one in twenty of all patients prescribed such therapy were women with these ‘disorders’ which included not only puerperal depression and menopausal depression, but also dysmenorrhoea in younger women and other menopausal symptoms which, it was noted, ‘appeared to cause much suffering’.⁸⁴

Published sociological research certainly began to suggest that tranquillisers were used increasingly to help individuals tolerate difficult personal circumstances. Many of these individuals were women who were living with partners who might have been displaying psychological symptoms but remained undiagnosed. Researchers pointed to cases, for example, where women were prescribed drugs to help them adapt to conflict in marriage and to intolerable behaviour by alcoholic husbands.⁸⁵ Although many women saw no alternative to pharmaceutical treatment, others expressed anger about their physicians’ approach and found alternative solutions to their problems.⁸⁶ Increasingly, sex role research revealed that male patients, when they did seek medical help, tended to discuss the onset of somatic symptoms – often in relation to work stress. In such cases, psychotropic drugs alleviated incapacitating symptoms, enabling them to continue work. Consistently in research, the most common symptoms related to chest palpitations and gastric symptoms. In rare studies that included combination preparations, the drug Librax emerged as commonly prescribed to men in such situations.

Footnotes


- 1 Parish PA. The prescribing of psychotropic drugs in general practice. *Journal of the Royal College of General Practitioners*. 1971;92 Supplement 4:1–77. on 1. [PMC free article: PMC2635262] [PubMed: 5143711] Parish undertook research into – and taught – pharmacology. He stressed the importance of teaching pharmacology to GPs.
- 2 Parish. The prescribing of psychotropic drugs. :1. For an account of the development of prescribing policy and prescription charges, see Baines Darrin. The prescription charge and the Hinchcliffe Committee. *Prescriber* (2013). 2013 November 15;:40–42.
- 3 See Tone Andrea. *The Age of Anxiety: A History of America’s Turbulent Affair with Tranquilizers*. New York: Basic Books; 2009. p.

196. For a full discussion of women and psychotropic medication in Britain see Haggett Ali. *Desperate Housewives, Neuroses and the Domestic Environment 1945–1970*. London: Pickering and Chatto; 2012.
- 4 For the history of this discovery, see Healy David. *The Antidepressant Era*. Cambridge Massachusetts: Harvard University Press; 1997. pp. 43–48.
- 5 Healy David. *The Creation of Psychopharmacology*. Cambridge Massachusetts: Harvard University Press; 2002. p. 4. [PubMed: 15272483]
- 6 Smith Mickey C. *A Social History of the Minor Tranquilizers: A Quest for Small Comfort in the Age of Anxiety*. New York: Pharmaceutical Products Press; 1985. p. 12.
- 7 Smith. *A Social History of the Minor Tranquilizers*. :12.
- 8 Today's Drugs, Benzodiazepines. *British Medical Journal*. 1967 April 1;:36.
- 9 Malcolm Lader argues that studies in the early 1960s indicated that there was the potential for dependence if benzodiazepines were used in large doses for prolonged periods, but that little notice was taken of negative reports due to the widespread perception of their safety. See Lader M. History of benzodiazepine dependence. *Journal of Substance Abuse*. 1991;8:53–59. [PubMed: 1675692]
- 10 Callaghan Christopher M, Berrios German E. *Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940–2004*. Oxford: Oxford University Press; 2004. p. 38.
- 11 Parish. The prescribing of psychotropic drugs. :6.
- 12 Parish. The prescribing of psychotropic drugs. :3.
- 13 Parish. The Prescribing of psychotropic drugs. :16. The survey included a total patient population of 133,081 registered with forty-eight GPs in the Midlands.
- 14 Parish. The prescribing of psychotropic drugs. :18.
- 15 Parish. The prescribing of psychotropic drugs. :19, 26.
- 16 Parish. The prescribing of psychotropic drugs. :26.
- 17 Parish. The prescribing of psychotropic drugs. :7.
- 18 Lee John AH, Draper Peter A, Weatherall Miles. Medical care: prescribing in three English towns. *Milbank Memorial Fund*. 1965;43(2, Part 2):285–290. on 288.
- 19 Parish. The prescribing of psychotropic drugs. :22.
- 20 Interview with Giles Walden.
- 21 British National Formulary (BNF). London: British Medical Association; 1952. p. 35.
- 22 Interview with Christian Edwards.
- 23 Interview with Richard Stanton.
- 24 Interview with Robert Manley. See also Moore Richard. *Leeches to Lasers: Sketches of a Medical Family*. Killala, Ireland: Morrigan; 2002. Moore recalled: 'mysterious substances like Syrup of Tolu and Pulv Tragacanth – relics of a bygone age' :220.
- 25 Interview with Giles Walden.
- 26 BNF. 1952:44.
- 27 For a cultural history of strychnine, see Buckingham John. *Bitter Nemesis: The Intimate History of Strychnine*. Boca Raton FL: Taylor and Francis; 2008.
- 28 BNF. London: BMA and The Pharmaceutical Society; 1960. p. 50.p. 57.
- 29 BNF. London: BMA and The Pharmaceutical Society; 1963.
- 30 Interview with Rupert Espley.
- 31 See Wilson CWM, Banks JA, Mapes REA, Korte Sylvia MT. Influence of different sources of therapeutic information on prescribing by general practitioners. *British Medical Journal*. 1963 September 7;:599–607. [PMC free article: PMC1872685] [PubMed: 14049985]

- 32 Wilson, et al. Influence of different sources of therapeutic information. :599. [PMC free article: [PMC1872685](#)] [PubMed: [14049985](#)]
- 33 Wilson, et al. Influence of different sources of therapeutic information. :601.
- 34 Wilson, et al. Influence of different sources of therapeutic information. :603. See also Wilson CWM, Banks JA, Mapes REA, Korte Sylvia MT. Pattern of prescribing in general practice. *British Medical Journal*. 1963 September 7;:604–607. [PMC free article: [PMC1872692](#)] [PubMed: [14049986](#)]
- 35 Dunnell Karen, Cartwright Ann. *Medicine Takers, Prescribers and Hoarders*. London: Routledge and Kegan Paul; 1972. p. 71.
- 36 Dunlop DM. A survey of 17,301 prescriptions on Form E C 10. *British Medical Journal*. 1952 February 9;:292–295. on 295. [PMC free article: [PMC2022787](#)] [PubMed: [14896121](#)] Dunlop went on to become the first chairman of the Committee on the Safety of Drugs, which was known for many years as the Dunlop Committee. Under his leadership, the Yellow Card Scheme was introduced in 1964, after the thalidomide tragedy highlighted the urgent need for routine monitoring of medicines. See The British Pharmaceutical Society. Hall of Fame: http://www.bps.ac.uk/details/resourcesPage/6215841/Sir_Derrick_Dunlop.html?cat=bps1465bf3219c. [accessed 7 January 2015];
- 37 Parish. The prescribing of psychotropic drugs. :62.
- 38 Parish. The prescribing of psychotropic drugs. :63.
- 39 Parish. The prescribing of psychotropic drugs. :69.
- 40 Parish. The prescribing of psychotropic drugs. :70.
- 41 Research in Psychopharmacology: Report of a WHO Scientific Group. Geneva: WHO; 1967. pp. 7–8.
- 42 Parish. The prescribing of psychotropic drugs. :14.
- 43 See for example, Dunnell, Cartwright *Medicine Takers*. Chapter 3., and Balint M, Hunt J, Joyce D, Marinker M, Woodcock J. *Treatment or Diagnosis: A Study of Repeat Prescribing in General Practice*. London: Tavistock; 1970. Chapter 4.
- 44 Advert for Libraxin. *British Medical Journal*. 1970 January 10;
- 45 Advert for Nactisol. *British Medical Journal*. 1965 December 4;
- 46 Advert for Stelabid. *British Medical Journal*. 1969 October 4;
- 47 See Silverstone JT, Lascelles BD. A double blind trial of Durophet M in the treatment of obesity in general practice. *Journal of the College of General Practitioners*. 1965;9:304–310. [PMC free article: [PMC1878427](#)] [PubMed: [19790565](#)]
- 48 BNF. London: BMA and The Pharmaceutical Society; 1974–6. pp. 5–6.
- 49 BNF. London: BMA and The Pharmaceutical Society; 1976–8. p. 36.
- 50 Interview with Christian Edwards.
- 51 Interview with David Palmer.
- 52 Interview with Glen Haden.
- 53 Interview with Rupert Espley.
- 54 Interview with Roger Lea.
- 55 Cooperstock Ruth. Sex differences in psychotropic drug use. *Social Science and Medicine*. 1978;12B:179–186. on 182. [PubMed: [725615](#)]
- 56 Cooperstock. Sex differences in psychotropic drug use. :182. [PubMed: [725615](#)]
- 57 Cooperstock Ruth, Lennard Henry L. Some social meanings of tranquilizer use. *Sociology of Health and Illness*. 1979;1(3):332–347. on 335.
- 58 Parish. The prescribing of psychotropic drugs. :66.
- 59 Dunnell, Cartwright *Medicine Takers*. :21.
- 60 Dunnell, Cartwright *Medicine Takers*. :21, 6.
- 61 Dunnell, Cartwright *Medicine Takers*. :13.

- 62 Sanatogen guard book 1944, foreign market, History of Advertising Trust.
- 63 Sanatogen guard book 1944, foreign market, History of Advertising Trust.
- 64 Advert for Rennies, JWT/GD/007, History of Advertising Trust.
- 65 Advert for Rennies, JWT/GD/007, History of Advertising Trust.
- 66 See, for example, Williamson Judith. *Decoding Advertisements: Ideology and Meaning in Advertising*. 2002 edition. London: Marion Boyers; p. 11.
- 67 Sadly, and perhaps with some irony, Harding died suddenly in 1960, at the age of 53, from a heart attack as he left BBC Broadcasting House.
- 68 The tricyclic antidepressants, for example, claimed to act on levels of serotonin and norepinephrine – the MAOIs claimed to reduce the breakdown of serotonin. For further information about the ‘marketing’ of stress, see also, Jackson Mark. *The Age of Stress: Science and the Search for Stability*. Oxford: Oxford University Press; 2013. Chapter 4.
- 69 Advertisement for Horlicks, February 1957, JWT/GD/101, History of Advertising Trust.
- 70 Advert for Rennies, 1958, SKB guard book 87, 1957–1958, History of Advertising Trust.
- 71 Advert for Rennies, 19 May 1938, JWT/GD/007, History of Advertising Trust.
- 72 Advert for Hemotabs (ND, circa 1950s), SKB guard book (012), History of Advertising Trust.
- 73 Parish. The prescribing of psychotropic drugs. :37.
- 74 A point made in many of the oral history interviews; however, many doctors preferred the traditional envelope style of storing patients’ notes.
- 75 Parish. The prescribing of psychotropic drugs. :38.
- 76 Parish. The prescribing of psychotropic drugs. :38.
- 77 Williams P, Murray J, Clare A. A longitudinal study of psychotropic drug prescription. *Psychological Medicine*. 1982;12:201–206. on 203, 205. [PubMed: 7079430]
- 78 Williams, et al. A longitudinal study of psychotropic drug prescription. :205.
- 79 Koumjian Kevin. The use of Valium as a form of social control. *Social Science and Medicine*. 1981:245–249. on 245. [PubMed: 7323846]
- 80 A topic covered fully in my earlier work, *Desperate Housewives*.
- 81 See for example, Cooperstock, Lennard Some social meanings of tranquilizer use. :336.
- 82 Murray Joanna. Long-term psychotropic drug-taking and the process of withdrawal. *Psychological Medicine*. 1981;11:853–858. on 855. [PubMed: 7323241]
- 83 Illustrated in a number of the oral history interviews.
- 84 Parish. The prescribing of psychotropic drugs. :41. See also, Watts. *Depressive Disorders in the Community*. :12–15.
- 85 See examples in Cooperstock, Lennard Some social meanings of tranquilizer use. :338.
- 86 Cooperstock, Lennard Some social meanings of tranquilizer use. :343.
- 87 Cooperstock, Lennard Some social meanings of tranquilizer use. :341. Such studies were usually undertaken in the United States.

Figures



Little boys are made of
 GOOD STRONG BONES, good tough muscle, and of loving care.
 Loving care is why those two lads are growing up strong—and Horlicks at night is part of that care.
 Horlicks, hot Horlicks, taken at bed-time. Helping a mother care for her sons. Helping her build their bodies into that strength on which health and happiness depend. Setting already the wise habit of a lifetime.
 A lifetime that will physically *need* that relaxed, perfect sleep which Horlicks helps to bring. The kind of sleep that makes each tomorrow a day full of energy and promise.

HORLICKS—with love—the grown-up drink for all of us

4170 K&C Horlicks Radio Times 6 Dec., 1957 101581 Final Proof No481

Figure 4.1 Advertisement for Horlicks, *Radio Times*, 6 December 1957

Source: Reproduced by kind permission of GlaxoSmithKline and the History of Advertising Trust Archive.



Figure 4.2 Iron Jelloids advert design, circa 1950s

Source: Reproduced by kind permission from Reckitt Benckiser and the History of Advertising Trust.

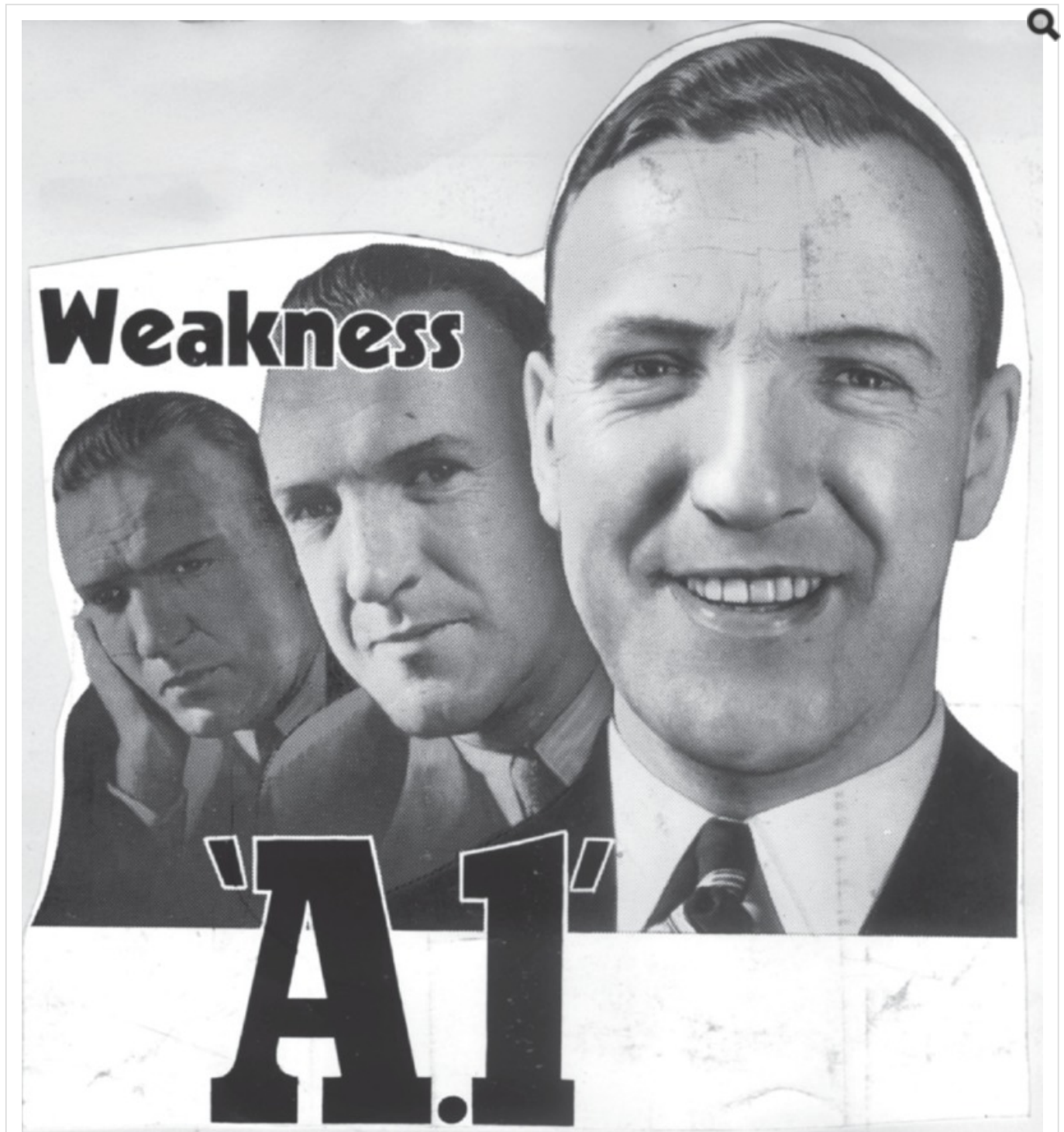


Figure 4.3 Iron Jelloids advert design, circa 1950s

Source: Reproduced by kind permission of Reckitt Benckiser and the History of Advertising Trust.



1948

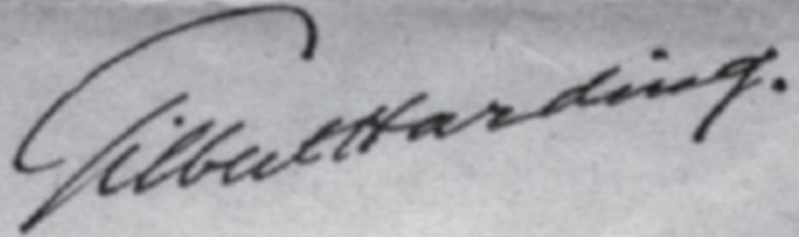
I think for myself

In our highly civilized society it seems incredible to me that there are still people who just don't bother to think for themselves — one remedy that I have been taking for years — Macleans Tablets. I am sometimes irritable be-

selves.

Take indigestion sufferers, for example. They never stop complaining. They may *get* indigestion — I get it myself. But they need never *suffer* from it. There's

cause I work too hard—and this gives me indigestion. But, believe me, Macleans tablets work—and work fast. I always carry some in my pocket! Anyone with any sense does the same.

A handwritten signature in cursive script, reading "Silbut Harding".

MEDICAL NOTE: *Double-action for longer relief. Macleans works in two ways — first, it gives quick relief from the pain and discomfort of indigestion. Secondly, Macleans has a new ingredient that keeps pain away. You get this double-action benefit from Macleans in handy tablets, 2/3 a carton, or in powder form, 2/6 a bottle.*

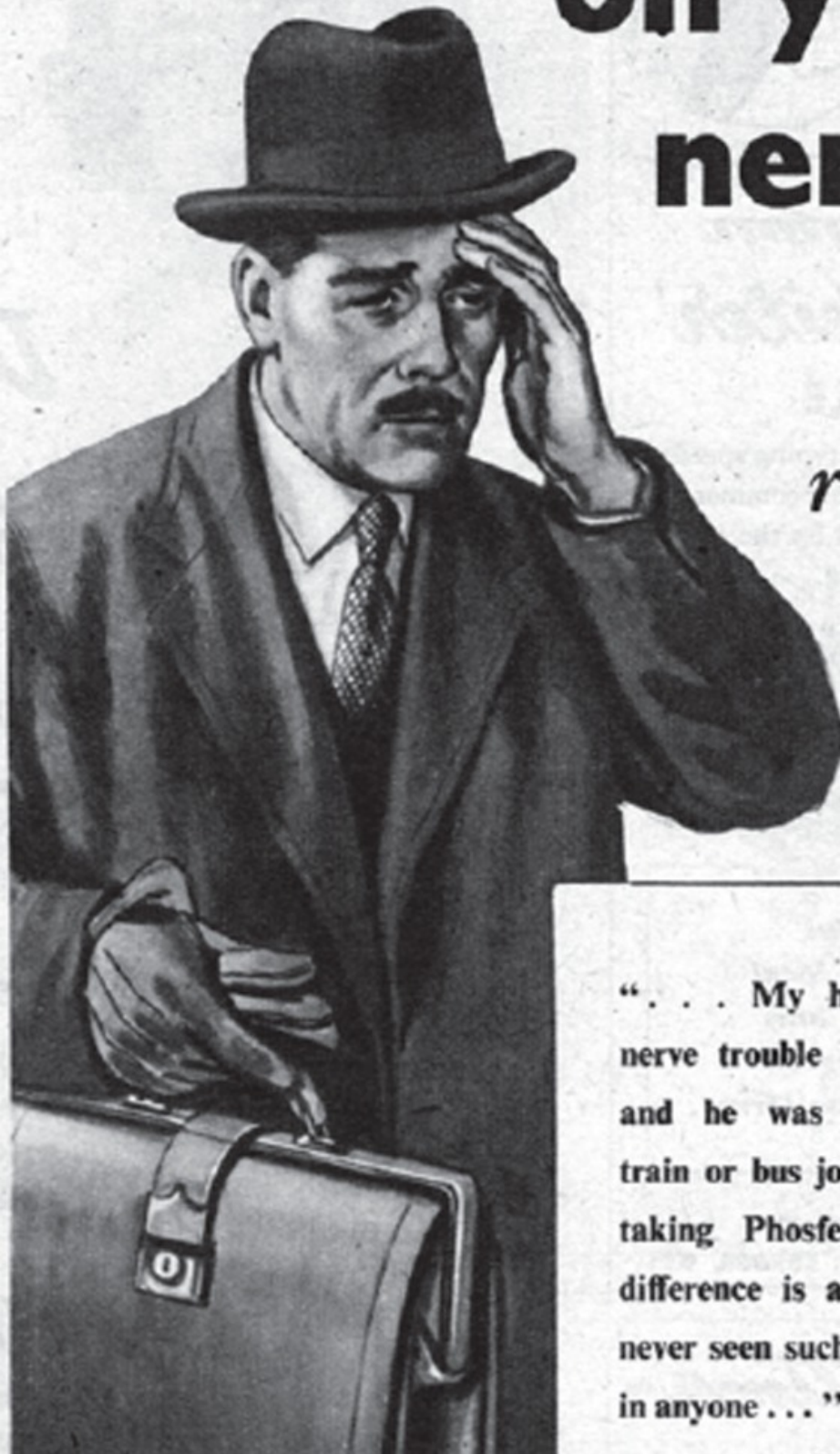
Figure 4.4 Advert for Macleans Tablets, 1959

Source: Reproduced by kind permission from GlaxoSmithKline and the History of Advertising Trust.

ILLUSTRATED - 26th February, 1955

If you're living on your nerves

*—then
read this
letter*



“ . . . My husband has had nerve trouble for a long time and he was dreading facing train or bus journeys, but since taking Phosferine tablets the difference is amazing. I have never seen such an improvement in anyone . . . ”

(Signed) E.M.P., London.

How PHOSFERINE overcomes nervous exhaustion

Medical research shows that between fifteen and twenty in every hundred people are over-anxious and subject to constant stress—in fact, LIVING ON THEIR NERVES. The remedy lies in strength regained and this is proved every day by the success of PHOSFERINE, which has helped so many—and could help you.

PHOSFERINE promotes a healthier function of the gastric nerves, which leads to a better appetite and restful sleep. Then, as you enjoy extra vitality, and once more face life calmly, you realise that this splendid tonic has been of benefit to your whole nervous system. Start taking PHOSFERINE today.



Available in Liquid
or Tablet Form
10 drops equal 2 Tablets

PHOSFERINE

PROMOTES GOOD HEALTH

520/25/55

Figure 4.5 Advert for Phosferine, 1955

Source: Reproduced by kind permission from GlaxoSmithKline and the History of Advertising Trust.

Tables

Table 4.1 Number of prescriptions, psychotropic drugs (England and Wales – in millions)

	1965	1966	1967	1968	1969	1970
Barbiturate hypnotics	17.2	16.8	16.1	15.3	14.2	13.1
Non-barbiturate hypnotics	2.9	3.5	4.8	5.8	6.3	7.1
Tranquillisers	10.8	12.5	14.7	16.0	16.5	17.2
Stimulants/appetite suppressants	5.3	5.2	4.8	3.9	3.6	3.4
Antidepressants	3.5	3.9	4.9	5.3	5.8	6.4
Total	39.7	41.9	45.3	46.3	46.4	47.2

Source: 'The prescribing of psychotropic drugs in general practice', *Journal of the Royal College of General Practitioners*, Supplement 4 (1971), 1. Reproduced with kind permission from the Royal College of General Practitioners.

Table 4.2 Psychotropic drug therapy, sex ratios (17.1% women to 8% of males per population at risk)

Therapeutic sub-group	Number of treatments			Ratio
	Female	Male	Total	Female to male
Barbiturate hypnotics	162	71	233	2.3 to 1
Non-barbiturate hypnotics	173	96	269	1.8 to 1
Tranquillisers	907	437	1,344	2.1 to 1
Stimulants and appetite suppressants	129	19	148	6.8 to 1
Antidepressants	264	110	374	2.4 to 1
Total treatments	1,635	733	2,368	2.21 to 1
Total sample of patients	1,140	528	1,668	2.14 to 1

Source 'The prescribing of psychotropic drugs in general practice', *Journal of the Royal College of General Practitioners*, Supplement 4 (1971), 20. Reproduced with kind permission from the Royal College of General Practitioners.

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