

---

# User surveys in psychiatry in the 1950s

---

## MEDICAL HISTORY

TORBJØRG STRAAND

**Torbjørn Straand (born 1965)** is a Specialist in Psychiatry and Senior Consultant at the Regional Psychiatric Centre, Skien.

The author has completed the ICMJE form and declares no conflicts of interest.

Department of Psychiatry  
Telemark Hospital

INGRID MELLE

**Ingrid Melle (born 1956)** is a Specialist in Psychiatry with special competence in psychotic disorders. She is head of the Psychosis Research Unit at Oslo University Hospital and Professor at the Institute of Clinical Medicine, University of Oslo.

The author has completed the ICMJE form and declares no conflicts of interest.

Division of Mental Health and Addiction  
Oslo University Hospital  
and  
Institute of Clinical Medicine  
University of Oslo

PÅL GJERDEN

**Pål Gjerden (born 1956)** is a Specialist in Psychiatry and PhD. He is Senior Consultant at the Early Psychosis Unit, Department of Psychiatry, Telemark Hospital.

The author has completed the ICMJE form and declares no conflicts of interest.

Email: [pal.gjerden@sthf.no](mailto:pal.gjerden@sthf.no)  
Department of Psychiatry  
Telemark Hospital

**From the 1950s until today, an increasing emphasis has been placed on assessment of patients' own experiences. In this article we will provide an overview of this development, elucidated with the aid of hitherto unpublished patient data from the 1950s. Assessments made by patients during this period have previously been unavailable.**



This is what the punch cards looked like. All sensitive information has been deleted.  
Photo: Einar Nilsen

Today, legislation states that patients are entitled to have a say in the treatment they receive, in somatic as well as psychiatric institutions. However, it was not until well into the 20th century that the issue of how patients perceived their treatment in psychiatric institutions was seen as relevant. Prior to this, changes had occurred in society, especially in the United States after World War II, when the new concept of «consumers' rights» was launched. First, this applied only to material objects. Ralph Nader's campaign against the car industry in many ways gave impetus to this development. Soon, the notion of consumers' rights also spread to other areas – to services and service providers, to medical treatment in general and to psychiatric treatment [\(1\)](#).

The first reports from psychiatric hospitals were published in the early 1950s [\(2\)](#). These were mainly sociological reports, focusing on the hospital as a system. The methodology most often consisted in observation, including participant observation, where the researcher acted as a pseudo-patient or a pseudo-employee. Describing the hospital structure was regarded as a simple, fairly objective collection of data, so that no further observers were required, nor was it necessary to ask the patients about their experiences.

In general, patients were regarded as unreliable informants, in addition these patients were mentally ill, which exacerbated their unreliability. In some cases unstructured interviews were conducted. The basis for drawing more general conclusions was not questioned. Most of these reports were very critical of the psychiatric hospitals; they were described as authoritarian systems that had a

negative effect on the patients. The fieldwork undertaken in Dikemark Hospital by the Norwegian sociologist Yngvar Løchen is an example of this tradition. His work was begun in 1956 and first published in 1960 (3).

The first study to focus on the views of the patients themselves was a PhD thesis from the University of Oregon in 1955 (4). The study emphasised the patients' *attitudes* to psychiatric institutions in general, not their specific experiences of the institutions where they had been admitted. This is the only study from the 1950s in which the informants are real patients.

It was not until the early 1960s that some studies related directly to the patients more or less systematically, in some cases with the aid of questionnaires. The questions were at first restricted to the patients' general attitudes to psychiatric treatment and psychiatric institutions, but gradually also included the *expectations* that the patients might have of the stay that lay ahead of them. Still, the patients' *experiences* of specific hospitalisations were little sought after. The first study we have found that investigated the patients' own experiences of a specific ward was published in 1960 (5).

In 1966/67, user participation became mandatory in the US, at first for the «community mental health centers». It was most likely this that contributed greatly to the increasing interest in the patients' own assessments, which in turn resulted in a large number of publications throughout the 1970s. The first Norwegian study of patients' experiences to be published was Johan Fredrik Thaulow's questionnaire study from Lovisenberg Hospital and Department 6B at Ullevål Hospital, undertaken in 1975 – 1976 (6).

---

## The University Psychiatric Clinic

Arne Straand (1917 – 1967) worked as a doctor and psychiatrist at the University Psychiatric Clinic at Vindern in Oslo from 1 April 1955 to 30 January 1964. At the time, the clinic was a government-owned institution with 100 patients from all over Norway. The clinic received people with disabling neurotic afflictions, depressions, alcohol abuse and acute psychoses (7). During this period, Gabriel Langfeldt was head of the clinic.

In 1963, Straand conducted a questionnaire-based survey among the patients who had been admitted in the course of a decade, with Leo Eitinger as his supervisor. The material was systematised, but for practical reasons it was never described or published. Arne Straand moved to Skien and Faret Hospital (now Department of Psychiatry, Telemark Hospital) in 1964, but died suddenly in 1967. This article describes those parts of his work that focus on the patients' own experiences.

In the early 1950s, the biological treatment options at the University Psychiatric Clinic at Vindern were mostly restricted to electroconvulsive treatment (ECT). The therapeutic environment was largely oriented towards tranquillity, rest and recreation-type work activities (8, 9). The material does

not specify the number of patients who received electroconvulsive therapy, but we know that the clinic used this as a standard form of treatment for depressive disorders throughout most of the period [\(10\)](#).

In 1951 – 52, the annual report first notes that all the clinic's doctors are interested in psychotherapy, and group therapy was introduced in 1957 [\(8\)](#). Psychoactive drugs were gradually being introduced in Norwegian psychiatric hospitals from the mid-1950s. Chlorpromazine and reserpine were introduced in Gaustad Hospital in the spring of 1954 [\(11\)](#). The irreversible monoamine oxidase inhibitor (MAO inhibitor) ipronazide was used at Vindern from 1957, but was discontinued after approximately a year because of its side effects on the liver. Imipramine came into use in 1958 [\(13\)](#) and chlorprothixene followed in 1960 [\(14\)](#). Somniferous drugs in the form of barbiturates had long been used; these were gradually replaced by meprobamate.

---

## Straand's study

The material in Arne Straand's study comprises patients who had been admitted to the University Psychiatric Clinic during the period from 1 July 1950 to 1 January 1961. During this period, a total of 7 283 patients had been discharged from the clinic. Altogether 468 of these patients received a questionnaire with nine questions (Box 1). The selection criteria for these 468 patients are not defined. Fully completed questionnaires from 209 patients are available.

---

### Box 1

#### *The questionnaire*

1. What was the reason for making your stay so short?<sup>1</sup>
2. What has your condition been like since your discharge?
  - a) Your ability to work?
  - b) Nervous afflictions, etc.?
3. Have you received medical care on a regular basis?
4. What medication have you used, if any?
5. Have you benefited in any way from your short stay at the clinic? If so, in what way?
6. Have you been admitted to a clinic for anxiety disorders or to a psychiatric hospital since you left us? If so, which hospital and when (year)?
7. Did you benefit from *that* stay?
8. Is your marital status the same now as it was during your stay at the clinic (i.e. married – unmarried – divorced)?
9. Do you have any other information?

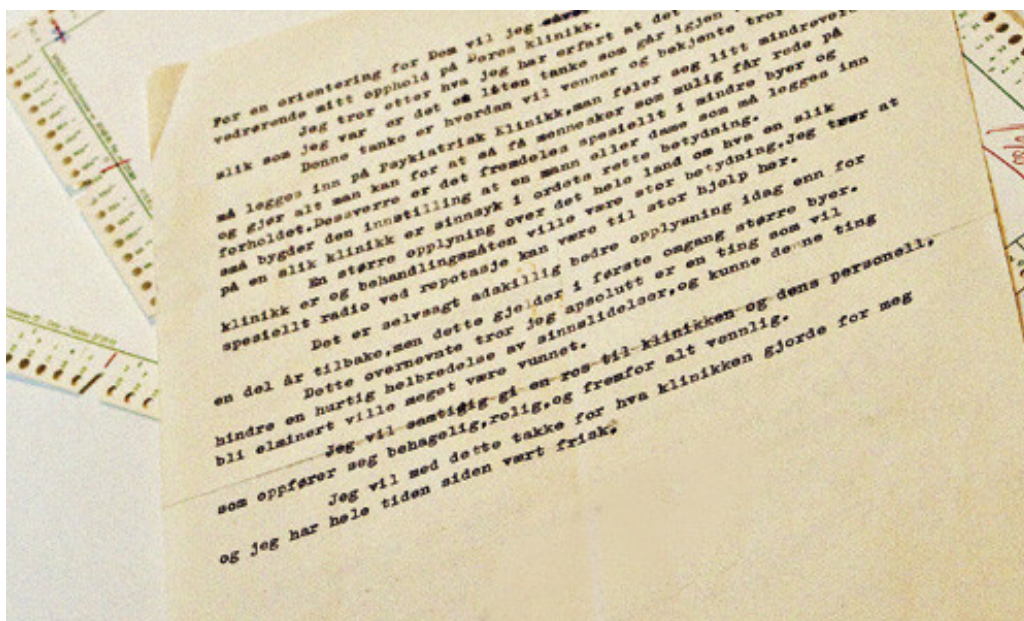
<sup>1</sup> This question was not used for patients who had been admitted for more than two weeks.

---

The responses were categorised and registered on punch cards – the method used at the time to systematise large amounts of data – along with information and assessments from the hospital records. Compared to the easily available statistics software we have now, the processing of punch cards appears almost inconceivably cumbersome. All the response alternatives to each question must be linked to a hole in the edge of a card. During registration, the hole corresponding to a specific answer is opened. When the information is analysed, knitting needles are poked through the holes for each alternative, the relevant cards drop down and are counted manually. This study used punch cards in an A4 format with 142 holes. The questionnaires are meticulously completed, and often include supplementary information and comments.

For 45 years the material was stored on punch cards before being statistically processed by Torbjørg Straand, who is Arne Straand's daughter.

The patients who completed the questionnaire were largely satisfied with their admission. More than half, 117 patients (56 per cent), felt that they had benefited from the stay at the clinic. Among the more specific reasons, a total of 21 patients (10 per cent) reported «being away from the habitual environment», while 17 patients (8 per cent) «saw others who were worse off and pulled themselves together», 27 patients (13 per cent) «learned something about themselves», and 52 patients (25 per cent) felt that they «received the appropriate drugs, could calm down and were understood». An example of uncategorised comments on the questionnaire is provided in Figure 1.



**Figure 1:** Comments from a patient. All sensitive information has been deleted. Photo: Einar Nilsen

One of the purposes of this post-hospitalisation study was to compare admissions that were shorter than two weeks to those that were longer. More than 90 per cent of those who had been admitted for more than two weeks reported that they had benefited from their stay at the clinic.

The questionnaire distinguishes between nervous disorders and ability to work: altogether 124 patients (59 per cent) suffered from nervous disorders, while only 27 (13 per cent) described themselves as unable to work.

A larger proportion of the patients who were discharged during the period 1956 – 1960 tended to function less well than those who were discharged during 1950 – 1955.

In the post-hospitalisation study, a larger proportion of those discharged during the second half of the period continued to suffer from nervous disorders when compared to those who were discharged during the first half, more of them saw a doctor regularly, and they perceived themselves to a lesser extent as healthy and able to work.

Possibly, this positive impression is exaggerated. First, we have no information on who was selected to receive the questionnaire. Furthermore, a number of factors may have had an impact on the responses of those who completed the questionnaire. At the time, the role of patient was more clearly defined, and the doctor was more widely accepted as an authority figure than is common now. Respect for authority may have induced the patients to express themselves in more positive terms than would really have been justified, but there is also a possibility that they felt obligated to respond as honestly as they could. At the time, questionnaire-based surveys were an unusual phenomenon, and we may imagine that they were regarded with a greater sense of earnestness than is the case today. The manner in which the questionnaires have been completed at any rate testifies to the patients having devoted a great deal of effort to their responses.

In those years, the expectations of having perfect health were most likely lower than they are today, among patients and in society as a whole. Looking at the responses, the views that prevailed in the fifties on personal health and the relevance of symptoms in relation to the ability to work appear different from those of our time. The patients seem to accept to a greater degree that they were able to and ought to work, in spite of their symptoms and afflictions. It is also possible that certain aspects of hospitalisation functioned better in earlier decades, for example by allowing more time for tranquillity and reflection compared to present-day requirements for effectiveness. The patients emphasised that they were «given appropriate medication, could calm down and were understood», while a more modern assessment would be likely to focus more on the importance of medication and understanding, and less on tranquillity. Even if we assume that the use of psychoactive drugs increased towards the end of the study period, we found no correspondingly positive changes in the patients' perceptions.

The patient data in this study are modest in volume and unsystematically selected. However, the study was one of the first to focus on the patients' own experiences, and had deserved to be published earlier. The experiences of these 209 patients provide a unique insight into institution-based psychiatric treatment during the 1950s. In addition, the study also gives rise to a question which remains relevant for present-day practices: How many psychiatric departments currently collect information on the patients' views about their treatment on a routine basis?

---

## LITERATURE

1. Thomson R. The whys and why nots of consumer participation. *Community Ment Health J* 1973; 9: 143 – 50. [PubMed] [CrossRef]
2. Weinstein RM. Patient attitudes toward mental hospitalization: a review of quantitative research. *J Health Soc Behav* 1979; 20: 237 – 58. [PubMed] [CrossRef]
3. Løchen Y. Det psykiatriske sykehuset i sosiologisk perspektiv. *Tidsskr Samfunnsforsk* 1960; 1: 205 – 21.
4. Souelem O. Mental patients' attitudes toward mental hospitals. *J Clin Psychol* 1955; 11: 181 – 5. [PubMed]
5. Fryling VB, Fryling AG. Patients' attitudes toward psychotherapy. *Psychiatr Q* 1960; 34 (suppl): 97 – 115.
6. Thaulow JF. Hva hjalp – og hvorfor – i en psykiatrisk klinikkavdeling? *Nord J Psychiatry* 1980; 34: 147 – 52. [CrossRef]
7. Kringlen E. *Norsk psykiatri gjennom tidene*. Oslo: Damm, 2007.
8. Eitinger L, Kringlen E. *Universitetets psykiatriske klinikk 1926 – 1976*. Oslo: Universitetets psykiatriske klinikk, 1976.
9. Dalgard OS. Evaluering av et psykiatrisk behandlingsopplegg. *Tidsskr Nor Lægeforen* 1977; 19 – 20 – 21: 1027 – 9. [PubMed]
10. Straand A. Behandling av depressive tilstandar med Tofranil (imipramin). Utprøving av Tofranil på friske personar. Professor Skjeldrups gullmedalje 1960/61. Oslo: Universitetets psykiatriske klinikk, 1961.
11. Lien JB, Straand A, Teigen A. Kliniske erfaringer med ataraxica. *Metodik og resultater*. *Nord Psyk Medlbl* 1958; 4: 261 – 8. [CrossRef]
12. Straand A. Kliniske røynsler med Marsilid (iproniazid) ved akutte depressive tilstander. *Tidsskr Nor Lægeforen* 1959; 8: 481 – 4.
13. Straand A. Behandling av depressive tilstandar. Kliniske røynsler med Tofranil. *Tidsskr Nor Lægeforen* 1960; 2: 69 – 74.
14. Straand A. Førebels melding om Truxal. Eit nytt psykofarmakon. *Tidsskr Nor Lægeforen* 1960; 19: 918 – 22.

---

Publisert: 6 March 2012. *Tidsskr Nor Legeforen*. DOI: 10.4045/tidsskr.11.0671

Received 10 June 2011, first revision submitted 12 December 2011, approved 15 January 2012.

Medical editor: Anne Kveim Lie.

© Tidsskrift for Den norske legeforening 2026. Downloaded from tidsskriftet.no 1 July 2026.