The Uses and Misuses of Television in Long-Stay Psychiatric and "Mental Handicap" Wards, 1950s–1980s

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In June 1949, the *Fulham Chronicle* newspaper (24 June 1949: 7) reported the success of an experiment that had taken place in a ward at the Western Hospital in South West London for patients with infectious diseases. The article explained how "[i]n pyjamas and dressing gowns patients … saw the Ascot Races simply by leaving their beds, walking down the ward and looking at the two-hour telecast from the course." Accompanying the short article was a photograph of nurses and patients crowding around the television set as a Mr. Wilfred Abery from the Beaufort Electrical and Radio Service pointed out "the highlights of Ascot racing on the television screen."

Television was catching on fast. Within a few years, it transformed the social and cultural life of Britain, bringing people together to witness and experience major public and sporting events from the comfort of their own living rooms or, as in the above case, hospital wards. In 1953, the coronation of Queen Elizabeth II was telecast to the largest national audience ever (Thumim 2002: 11), boosting the sale of television licenses to over 1 million (Moran 2014: 73). By 1961, 75 percent of British households owned a television set, which increased to 91 percent in 1971 (Marwick 2003: 91). According to John Hartley, television played a vital part in a new "ideology of domesticity" and the long-term transition of built spaces from "dwellings" to "homes" (1999: 105–106). In America, almost two-thirds of homes had installed a set by 1955, rising to nearly 90 percent by 1960 (Spigel 1992: 1). Indeed, its rapid rise in popularity provoked alarm. From the 1950s, numerous studies were conducted into

the effects of television programs on children and family life.[1] Concerns were raised around how portrayals of violence influenced young and malleable minds, stoking fears about its links with delinquency as well as its destabilizing effects on the rhythms of family life and gender relations. In Britain, it was frequently criticized as an agent of American cultural imperialism and consumerism (Wood 2015; Moran 2014; Thomson 2013: chapter 4; Oswell 2002; Thumim 2002; Corner 1991). Less work has been devoted to the television set as an object and the activity of watching it (Black 2005: 548). In her article "The Material Form of the Television Set," Deborah Chambers (2011) demonstrates how the design, size, and portability of the television set symbolized social class and status, as well as recalibrating familial relationships inside the home. This changed the relationship "between private and public space

as part of a narrative of domesticity and progress," which in the case of portable televisions altered viewing habits from more social events that promoted family bonding to an activity of "personal indulgence" (2011: 372–373).

Television was also finding its way into different institutional settings, including psychiatric and "mental handicap" wards[2], many of which already had a "wireless" or radio. Black-and-white television sets began to appear on wards during the 1950s (Sherrett 1958), while color televisions grew in popularity from the late 1960s (Moran 2014: 162). Both were expensive and often donated to wards by former patients and charities, or by families or friends of patients (Graffy 1983). In her study of the role of television in American public spaces such as shopping malls and airport lounges, Anna McCarthy examines the relationship between television and temporality by exploring its role in "the act of waiting" in hospital waiting rooms. She has observed that "often associated with *wasting* time, watching television is a way of passing time suddenly *legitimized* when it takes place in waiting environments" (2001: 199). Yet, hospital waiting rooms and public spaces more generally were built for more transient populations and embedded into large infrastructures with a different mix of interests.

Despite the growing ubiquity of televisions in hospital wards in the UK and America from the 1950s, little in-depth research appears to have been conducted by historians on the relationality between the new technology, the long-term ward space, and its occupants. In this essay, I draw mainly on studies that were conducted in the post-war period by social scientists and social psychiatrists primarily in Britain, but also in America and Canada, into the effects of the ward environment on patients. While long-stay psychiatric and mental handicap wards were occupied by people with different mental and physical abilities and needs, often at different stages of their lives, I want to demonstrate how the mutable ontology of the television set could affect the lived experiences of vulnerable patients who, unlike those in the Western Hospital, had little agency. How, I ask, did the television as an object in and of itself gain agency and influence the rhythms, routines and social relationships within different spatial and temporal contexts? How, in the words of Janet Thumim, did it become "part of everyday life, part of mundane experience in ways that fundamentally alter previously crucial structuring boundaries such as those between past and present, here and there, self and other/s" (Thumim 2002: 3)? Contrasting the ways in which the activity of television watching was constituted by perceptions of patients' cognitive, intellectual, sensory, and physical abilities in different ward spaces reveals much about attitudes and practices of the time.

From Space to Place

The closest historical study to address the impact of television on residents in a large semi-bounded community is a fascinating account by historian Christina von Hodenberg (2016) on how television changed communal relations in a small and remote rural farming village in West Germany. Drawing on a rich archive of sources gathered by "gloomy" ethnographers over three decades from the 1950s, von Hodenberg describes how traditional community life changed as village residents purchased their own television sets and withdrew from communal spaces and activities in order to watch at home. The daily routine of village life changed. An early-to-bed, early-to-rise rhythm was disrupted as villagers sat up late, glued to their screens. In the summer, those who had previously sat outside their houses to chat with neighbors preferred to stay at home to watch television. People became better informed of current events and less dependent on the counsel of the church and village authorities.

I am not suggesting that a small village in West Germany is comparable to a large mental institution. But there were some resonances given that both communities were porous yet bounded, and isolated from larger urban areas. Von Hodenberg argues that while television had a huge impact on the reconfiguration of family life and small communities, dissolving urban/rural boundaries and accelerating the "modernization, secularization, nationalization and politicization" of rural societies, the old patriarchal system prevailed (2016: 842, 865). The television played a similar role in large institutions by dissipating the borders of the public/private spheres that kept patients separate from the world outside, while changing social relations and the meanings of space inside, reinforcing and re-constituting different networks of power.

The study drawn on by von Hodenberg was one of many conducted from the 1950s by a new generation of social scientists. Some subjected large mental hospitals in Britain and the US to particular scrutiny in an endeavor to understand the effects on people of living and working in overcrowded, broken-down, and understaffed institutions (Stanton and Schwartz 1954; Caudill 1958; Goffman 1961).[3] That asylums and hospitals were detrimental to patients' physical and mental health had been known for decades, but it was not until this post-war period that the institution began to be framed as pathological in its own right. Terms such as "institutionalization" began to gain currency (Martin 1955). In Britain, Russell Barton, the social psychiatrist and medical superintendent of Severalls Psychiatric Hospital in Essex, used the term

"institutional neurosis" and published a book in 1959 in which he enumerated a number of factors which, in his opinion, gave rise to such a condition.[4] One was the "ward atmosphere," which in the third edition from 1976 included "noise" such as "clatter of ward activity, jangling of keys, television sets playing, doors slamming, telephones ringing, noise of electric cleaners, patients shouting and sounds coming from without" (Barton 1976: 19). From the mid-1960s, television documentaries and newspaper exposés began to reveal in horrifying detail how many of society's most vulnerable people – often older people and people with severe learning disabilities – were "cared for" in grossly inhumane conditions. Such revelations ramped up the volume of the call to close the big institutions and to relocate patients back to their families or to smaller residential homes in the community.

This process did not begin in earnest until the 1980s. Meanwhile, tens of thousands of people were still living on long-term wards, which were "home" for many. The domestic character of these wards can be traced back to the mid-19th century when homely effects were intended to have a "civilizing" influence on patients' behavior (Hamlett 2015). The ward was a place of containment where patients were categorized and managed according to the levels of "care" they were believed to need. It was also a quasi-clinical space, run in Britain by the *National Health Service* (NHS) from 1948. Doctors, nurses, and other clinicians might have been trained in psychiatry – not everyone was – but much of their work related to the physical care of patients. Older people were believed to be suffering from irreversible conditions such as "senile dementia" that could not be treated (Hilton 2016). It was assumed that little could be done for those with severe and/or multiple learning disabilities, although people with milder disabilities might expect to leave the institution once a suitable home for them in the community had been found. Long-stay wards were, therefore, both public and private spaces. Clinical, domestic, institutional, and in some respects carceral, they were hybrid environments that were ambiguous by nature. When television sets arrived, they not only added to the domestic atmosphere by reflecting the family home outside but gave wards a visible boost of modern technology. They played a therapeutic role by amusing and occupying as well as educating and informing more able and well patients.

Yet, as Jane Hamlett has noted, not everyone saw the hospital ward as "home" (2015: 7). Space becomes place when, according to Tim Cresswell, "humans invest meaning in a portion of space and then become attached to it in some way" (2015: 16). This could have been the whole ward environment, or just a corner of a room which might be given a specific meaning by an object. Benoît Majerus has demon-

strated how material culture gains agency by showing how a bed "changes its function when transposed from a standard room to an asylum" (2017: 272). Once a space had been designated for the television, chairs would be arranged around it in a semi-circle or in cinema-style rows that were lined up in front of it (see fig. 1). Inserting the television as both a medium and an object into a ward space changed it to a place which had myriad meanings for different people at different moments in time, particularly when certain programs were being shown. The significance of the television space would not have been the same for older patients who were "parked" in front of a screen for the better part of the day as it was for the patients in the Western Hospital who eagerly crowded around the set to watch the Ascot races in full knowledge that they could walk away when the last horse crossed the finishing line.

"Consciousness constructs a relation between the self and the world," writes Cresswell. Drawing on Edward Relph, he explains how humans can only exist "in place," so "place determines our experience" (2015: 38). Yet, landscape or "the world out there," Barbara Bender notes, "refuse[s] to be disciplined" as it invokes "both time and place, past and present, being always in process and in tension." The ontological status of human and non-human actors and objects constantly shifted within the subject/object dyad constituting and reconstituting relations (Bender 2006: 304). This, I suggest, made for a highly unstable ward environment with no single or secure meaning for its residents, particularly for those with diminished agency and ability to create a secure sense of "being" within it.

In her work on cancer narratives, Victoria Bates explores how the senses construct a phenomenological experience of place which is tied to notions of recovery and illness, noting how "the same sensory environment can be a different place over the course of an illness" (2019: 10). There was little expectation of recovery on long-stay wards. On "geriatric" wards for older people, the prognosis for many patients was rarely more hopeful than gradual deterioration and death. The *Nursing Times* reported in 1966 "that a very great number of elderly people sit waiting for death in mental hospitals, where they have no business to be" (cited by Robb 1967: 10). Attitudes were different on mental handicap wards where, depending on the perceived and actual severity of their disability, both children and adults of different ages might expect to spend the rest of their lives in an institution, or to leave the hospital and live in the community.

Many hospitals began to implement rehabilitation programs to prepare as many people as possible for life in the community. Resources were tight. Progress was slow. Ward doors started to be unlocked to allow patients to move freely around the

hospital and to mix with each other unchaperoned. New methods were introduced that transformed some wards which had previously been run along quasi militaristic lines into therapeutic communities involving more meaningful interactions between the nursing staff and patients. Although reservations were sometimes expressed around installing televisions on wards, broadly it was seen as a good thing. In 1969, Dr. J. Gibson from St. Lawrence's Hospital for people with mental handicaps described the implementation of the latest reforms: wards had been opened; the sexes were allowed to mix; food, clothing, and heating had improved.[5] Furthermore, television sets had been introduced onto the wards, which he claimed "brought the patient more sharply into appreciation of the outside world and has entertained and educated him" (Gibson 1969: 592). In the 1980s, David Hughes and his team conducted an ethnographic study of a single ward called Ward Twenty, which had been established to provide young people with learning disabilities in Scotland with a less institutional and more "family" style of life. They reported that the television was usually on all day, with Hughes commenting that "what patients come to know about such areas as relations between the sexes, and many aspects of everyday family life, almost certainly derives in large part from what they see on the small screen" (Hughes et al. 1987: 391). For those who were getting ready to leave institutional care, television could potentially have helped to prepare them for life outside, even though the "world" patients viewed was carefully constructed and mediated by two broadcasters competing for audiences' attention: the BBC, which was funded by license fees and considered informative, educative and paternalistic; and ITV, which dished up a menu of light entertainment, old films, and soaps that were paid for through advertising (Donnelly 2005: 77–79). Television did, therefore, play a role in the deinstitutionalization process. Often described as a "window on the world,"[6] it dissolved some of the notional boundaries between the hospital and the world outside, between the private and the public spheres.

The real therapeutic benefits of television were believed to be gained not through the direct interaction between a patient and the TV screen but through a triadic relationship between patient, television, and staff involving activities and interactions based on programs they had watched together. At Severalls Hospital, patients were allowed a limited amount of television watching. On Sundays, they could watch from 5 to 7 p.m. Then, after visiting and supper time between 7 and 8 p.m., patients who needed "supervision" were put to bed, while others were permitted to watch television until 10 p.m., which was to be followed by a brief discussion of the programs viewed. For Barton, it didn't matter what they discussed; it was "participation

in the discussion that counts" (1976: 42–44). Engagement between patients, staff, and the television took "watching TV" into the territory of occupational therapy which nurses, rather than qualified occupational therapists, provided in some mental handicap hospitals (Jones 1975: 27–28). In the early 1960s at Holywell Hospital in Northern Ireland, the ward staff devised a series of activities and music evenings that were based on television game shows and popular programs such as "Twenty Questions," "Juke Box Jury," and "Top of the Pops." Both staff and patients participated in these games, all competing with each other (Prior/McClelland 2013: 405).

Attitudes towards staff engagement with television were ambivalent, even when it was for the patients' benefit. A major concern in both general and psychiatric hospitals in America and Britain was that it would distract nurses from their work (Fuqua 2003: 242). Many institutions operated a strong task-centered, rather than patient-centered, culture where nurses focused on keeping the ward looking clean and tidy but had little meaningful interaction with patients. When not actively occupied, they might prefer to remain in the nurses' station or office. Sociologist Pauline Morris carried out a major survey of almost half the hospitals for the "subnormal" in England and Wales during the 1960s. She remarked that in one institution, even when a shift was well staffed, nurses stood "around talking to each other" rather than interacting with "fifty older children wandering around aimlessly or sitting making noises" (2006 [1969]: 170). Television could entice staff out of their office. The American psychologist D. L. Rosenhan (1973) noted how nurses would occasionally emerge from "the cage" – a glass station that allowed them to observe patients – to give medication, speak to a patient etc., and to watch television in the dayroom, even though they tended to keep to themselves. During an inquiry into abuse at South Ockendon Hospital in East London, one nurse asserted in the early 1970s that she had been most distressed by the patients' "clothing and appearance," and how they were "forsaken-looking." She stated that "the staff were looking at television, and the patients needed attention" (Committee of Inquiry 1974: 92).

In some hospitals, especially those which were short-staffed, television was a convenient way of trying to keep patients occupied with as little effort as possible. In the hospitals she visited, Morris observed that "[a]lmost all wards were equipped with items which entertained the patients with the minimum of supervision, i.e. television and radio" (2006 [1969]: 91). Following a visit to a mental handicap hospital, she noted that there was nothing to suggest that "television and radio programmes or reading matter were chosen with the cognizance of the abilities, needs and interests of the patients" (ibid.: 226). These items were purchased by charities

such as the *League of Friends*, which, Morris argued, could have spent their money better by providing comfortable chairs, which wards were in desperate need of. Indeed, Morris reported that over 89 percent of patients were in wards with a television, radio, and record player, compared to 70 percent of patients who were in wards providing toys, games, or books (ibid.: 91), which generally required more interaction by staff. However, given that television was a regular feature of domestic spaces by the late 1960s, the absence of a ward set may have given the impression of depriving residents of a valued source of entertainment and enjoyment.

Other hospitals did attempt to engage more fully with the potential therapeutic effects of television. In their study of three anonymized mental hospitals in England and Wales conducted in the late 1950s, sociologists Kathleen Jones and Roy Sidebotham reported that long-stay wards in one mental hospital employed special "television nurses" – described as "married women who work part-time" – on the female side. Their role was to attend to the patients during "television hours" in order to free the regular staff to attend to other tasks (1962: 59). This practice mirrors those recorded by Joy V. Fuqua (2003), who examines how television was integrated into general hospital nursing practice in America in the post-war period, when TV hostesses were employed to meet patients' viewing needs and to ensure that nurses were not distracted from their work.

Well aware of the adverse effects of watching too much television and the temptation of using it to keep patients quiet, some hospitals went to considerable lengths to discourage too much viewing. Jones and Sidebotham reported how one hospital placed television sets in dining rooms where chairs were hard in order to encourage patients to find other "more profitable forms of activity" and not just to "keep patients quiet" (1962: 87). At Severalls Hospital, Russell Barton devised a timetable of activities that offered patients more stimulating and sociable activities. He was not alone in believing that activity could reduce "aggression, tearing, picking, hoarding, masturbation and other undesirable behavior." While he believed that "television was useful to fill in some evenings," he argued that "it is better to *do* something than to watch something" (1976: 42, 44, my emphasis).

Concerns in wider society that too much television watching would replace more valuable social activities were reflected in hospitals. Pauline Morris (2006 [1969]: 185) explained how dances (often single-sex) became less popular with patients after televisions were introduced on the wards. They did, however, tend to be more popular with male patients. Morris suggested that this may have been because men were less bothered about their appearance and easier for the nursing staff to get

ready. While the men were at the dance, the women might be watching television, reflecting national trends which claimed that children and older people watched the most television, and that it was more popular among women than men (Marwick 2003: 206). However, if there were no other forms of activity available, Morris (2006 [1969]: 170) reported that on the male wards in one mental handicap hospital patients tended to play billiards or watch television, while on the female wards a few women might sew, knit or do jigsaws. Both sexes watched television depending on the wider context in which it was available.

The Meaning of "Watching"

In 1972, Noel Wharton published a study of two "crib" wards in a state institution for the "mentally retarded" in Ohio. Patients were described as having "limited or non-ambulation capacity" which meant spending most or all of their time in a crib. Staff on the female ward, he reported, would spend the most time with patients between dinner time and bed time "usually watching television" together (1972: 127, 131). In this section, I examine the meaning of "watching" television. Was it an activity? Did it, as Barton questioned, imply *doing* something? Did it need the interaction of staff to legitimize it as such? What did it signify for patients who were unable to engage with it in a meaningful way? A 1974 Canadian study into the patterns of activity and uses of space on three wards in a large mental hospital classified watching television as "[m]ixed active behavior" alongside listening to the radio, eating, or housekeeping with others (Willer et al. 1974: 458). This ambiguous classification allowed the act of watching television to be imbued with a multitude of meanings depending on the temporal and spatial context as well as the subjectivity of the individuals who were "doing" the watching, or not. I have discussed above how three-way interactions between television, patients, and staff could be therapeutic. In this section I turn to the very large number of patients, many with severe cognitive and sensory impairments, for whom television reinforced the harmful effects of the institution.

In the early 1960s, researchers John Cumming and Elaine Cumming reported how the huge dayrooms in the "chronic wards" of Weyburn Hospital in Saskatchewan were "lined around the edges with chairs – like an enormous waiting room" (1962: 101). They noticed how patients tended not to sit in these rooms, but on floors of the hallways watching the attendants and doctors go by, commenting that patients

would always seek out places "where interaction is highest." This suggests that watching the coming and going of staff on the ward was a meaningful activity for patients who preferred to observe a world to which they felt some connection, however mundane and routine. This, then, raises the question of how patients who were unable to choose where they would spend their day or evening experienced being "parked" or coerced to sit in front of the television with little say in the matter.

Over the weekend in Ward Twenty, when not much was going on and fewer staff members were on duty, the television and radio or record player tended to be on all day because nurses were not obliged to organize any activities. Staff remarked on how the children were "watching TV," giving the impression that they were *doing* something, even though there was little interaction between the television set and the children. Few appeared to be engaged with the programs (Hughes: 406, footnote 7). Morris noted that in one hospital where the television was on constantly in the day rooms "one patient … preferred to escape the cathode tube image by sitting alone in an ill-lit lavatory, quite absorbed in reading seed catalogues!" (2006 [1969]: 232).

For those who were unable to remove themselves from the set, its effects reached beyond engendering poor posture and inactive bodies, or of rendering minds numb and passive (Black: 2005). For many, it caused deep psychological and emotional stress. First, as we see in figure 1, patients may have been placed in chairs facing the television screen but with their backs to the ward, psychologically dislocating them from ward life and disrupting their sense of feeling anchored and secure in their environment. Second, many people were mentally unwell and/or experienced severe and profound cognitive impairments which would have limited the degree to which they could engage with and follow television programs, if at all. This was exacerbated by the pernicious practice of routinely removing spectacles and hearing aids on some British geriatric wards, making it harder to see and hear the television (Robb 1967: xiii). Third, the sound emitted from televisions and radios was known to be stressful. One seriously ill woman in a general hospital reported in 1959 how she suffered "absolute torture" due to the constant noise of the television, which other patients did not want to switch off (Observer 1959: 5). A recent study into the environment of a home for people living with dementia in Canada suggests that "excessive ambient noise" such as that made by staff, other residents, and television or radio agitated patients, negatively affecting social interactions in special care units (Campo/Chaudhury 2011). As Bates notes, sound becomes intrusive noise, especially when one is anxious and has no control over it (2019: 18). In many general hospitals, patients were given headphones so that the television did not

disturb other patients (Liverpool Echo 1960: 9; Coventry Evening Telegraph 1976: 5). Even though this gesture was mooted for long-stay mental hospital wards from the 1950s (Warwick and Warwickshire Advertiser 1951: 12), I have yet to see a report of headphones being used in this context.

To contain noise, some hospitals designated special television rooms that were away from the main ward area. This did reduce stressful background din on the ward, but it could also isolate some patients even further. In the male crib ward in Ohio, some patients would be "gotten up" before being taken in wheelchairs to the dayroom where they were placed in front of the television and left there for some hours. They rarely spoke to each other "unless to comment on something that happened on the television or in the hall outside" and became isolated because the room was separated from the rest of the ward. They were returned to the same room for a couple of hours after dinner in the evening, when staff might "duck in and out ... briefly interacting with patients" (Wharton 1972: 131–132). The presence of the television in this room did, therefore, legitimize the practice of placing patients inside this container within a container where their presence would almost certainly have been questioned had the television not been there.

Technology of Control

One evening, when a new seating arrangement was implemented on Ward Twenty, children were reported to have been "placed in unusually neat rows with the seats facing the T.V." Those who normally sat on the floor in order to see and hear the set better were instructed to sit on the chairs, even though some of them were short-sighted and not able to see the television because their glasses were kept at school (Hughes et al. 1987: 388). This notion of the television as an agent of control is reflected in accounts from other institutions. One doctor at a hospital for "mentally defective" children in Somerset, England claimed in 1955 that the children's behavior improved during the hours leading up to the television being switched on, so that they might "not be stopped from attending on account of misbehavior" (De M. Rudolf 1955: 59).

The television's role as a technology of control was woven into practices on adult wards as well. In an environment in which patients were so often infantilized, watching television at night conferred on them a certain adult status denoting

that they were mature enough to watch programs which could include violent and sexualized content. At night, television spaces became adult spaces. In one private hospital in Boston, patients were granted "television privileges," which meant they could stay up late in return for good behavior (Segal 1962: 262). One psychiatric social worker with a father in one of the big London psychiatric hospitals explained how she visited him one evening and found that he was already in bed by 7 p.m. He claimed that because he was not on a ward with a television set, he and all the patients were "settled down early" (Robb 1967: 61–62). In other words, patients were "managed" and "kept quiet" in the evenings, either by being put to bed (often with a sedative) or by being allowed to watch television, *if* they had earned the privilege. Being allowed to stay up late and watch television became a reward for good behavior. Patients who had this privilege withdrawn could consider themselves punished (Jones et al. 1975: 25, 112). Patients not only had to earn the right to stay up late and watch television; they had to earn the right to be treated as an adult. It was through the agency of the television set that this was made possible.

Conclusion

Since the mid-19th century, wards for the long-term care of people who were mentally unwell or with intellectual disabilities were in many respects hybrid domestic and quasi medical spaces of containment. In this essay, I have argued that these characteristics continued well into the 20th century and imbued the objects and people inside them with multiple and mutable meanings. Consequently, the implementation of objects such as the television set could be misused and even abused, which created an unstable and insecure environment particularly for the most vulnerable patients able to exercise minimal agency.

  Some patients enjoyed watching television. As a medium, it could have therapeutic value that could help to forge stronger bonds between staff and patients, and dissolve boundaries between the institution and the wider world, sometimes playing an important role in preparing patients to move out of the hospital and live in the community. Quickly absorbed into the spatial and temporal landscape of the ward, it soon became embedded in networks of power and invested with agency that changed and shaped rhythms, routines, behaviors, and even identities. But television could also legitimize practices which excluded some of the most vulnerable

patients from ward spaces and increased the stress felt by those who were left in front of it for hours on end, thus maintaining the appearance that they were doing something.

The television set was and continues to be a powerful technology in and of itself. When used discriminately and thoughtfully, it could add to the quality of life of long-stay patients; when used indiscriminately, it could be pathological and reinforce the harmful effects of institutional living.

Notes

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1
John P. Murray (1980) included a bibliography of 3,000 citations relating to the effects of television on children between 1955 and 1980.

2
I use the terminology of the period and inverted commas for first mention only.

3
In 1954, the number of people packed into mental institutions in England and Wales exceeded an unprecedented 151,000 (Jones 1993: 161); 46 percent were estimated to have lived in the institution for over ten years (Turner et al. 2015: 605).

4
In Britain, these included the *News of the World* 1967 report on Ely Hospital in Cardiff and a 1968 *World in Action* documentary on the appalling conditions in Ward F13 at Powick Hospital in Worcestershire.

5
Despite so-called "improvements," the 1981 documentary *The Silent Minority* revealed the shocking conditions in which people were still living at two hospitals, one of which was St. Lawrence's.

6
The current affairs program Panorama used the subtitle "Television's window on the world," http://news.bbc.co.uk/panorama/hi/front_page/newsid_7753000/7753038.stm, accessed July 11, 2019.

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