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References

- 1 Costello EJ, Maughan B. Annual research review: optimal outcomes of child and adolescent mental illness. *J Child Psychol Psychiatry* 2015; **56**: 324–41.
- 2 Goodyer IM, Wilkinson PO. Practitioner review: therapeutics of unipolar depression in adolescents. *J Child Psychol Psychiatry* 2019; **3**: 232–43.
- 3 Schweizer S, Segal Z, Speckens A, Teasdale JD, Van Heeringen K, Williams M, et al. Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: an individual patient data meta-analysis from randomized trials. *JAMA Psychiatry* 2016; **73**: 565–74.
- 4 Dunning D, Griffiths K, Kuyken W, Crane C, Foulkes L, Parker J, et al. Research review: the effects of mindfulness-based interventions on cognition and mental health in children and adolescents – a meta-analysis of randomized controlled trials. *J Child Psychol Psychiatry* 2019; **60**: 244–58.
- 5 Racey D, Fox J, Berry V, Blockley K, Longridge R, Simmons J, et al. Mindfulness-based cognitive therapy for young people and their carers: a mixed-method feasibility study. *Mindfulness (N Y)* 2018; **9**: 1063–75.

psychiatry in history

Henry VI: catatonic stupor, and the case series of 15th-century psychiatric miracles attributed to his posthumous intercession

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In early August 1453, Henry (1421–1471), ineffectual King of England and France, ‘the Founder’ of Eton and King’s College, Cambridge, was ‘smitten with a frenzy and his wit and reason withdrawn’, reputedly due to an unexpected fright – news of defeat at Castillon on 17 July 1453, with the loss of nearly all English holdings in France. Aged just 31, Henry did not talk, sat slumped, had to be fed and moved, did not recognise or respond to others and was incapable of government for a year and a half despite all medical attention. About New Year’s Day 1454, no response but a glance was elicited from him when Queen Margaret brought ‘her son’ Prince Edward (born October 1453 – and rumoured illegitimate) for blessing. In March, a delegation of Lords could elicit no answer from him. By September, he was capable of handing the Cross of Office to the Archbishop of Canterbury. At Christmas-time he revived. He asked the Queen his son’s name and said that until then he had not known where he had been nor what had been said to him. Afterwards, there are suggestions of persistence and/or relapse. *Rota Fortunae!* Henry was imprisoned in the Tower of London in 1465; restored in 1470; and, in 1471, returned to the Tower and allegedly overcome by melancholy and/or murdered on Edward IV’s orders (Henry’s remains were exhumed in 1910 – his skull was broken in several places).

Henry’s body was placed at Chertsey Abbey, where a cult developed on his reputation for sanctity and miracles. In 1484 his relics were moved to the Chapel of St George at Windsor, which became a healing shrine of national importance. Pursuit of canonisation (failed) instigated the preservation of miracles attributed to him. Original depositions by monks in English detailed at least 368 but are lost. The surviving record is a redaction of 174 in Latin, identified by name, date and place – implying accurate recording. Psychiatric and other claimed miracles, including children, adults, animals and accidents, are described in matter-of-fact, if not credulous, detail. Some 24 depict: madness; depression supervening on pain, physical illness and disability; suicide, attempted by throat cutting and hanging; and chronic somatic and neuropsychiatric symptoms. Miraculous recovery was essential, supporting psychosocial process or natural resolution. For example, Ashby St Ledgers, Northamptonshire, 23 July 1486:

‘The wife of Geoffrey Brawnston became disturbed one hot July. The onset was sudden, with a rapid build-up to fury: she roamed immodestly, and was a pest to all. After a day, she came to the church when the congregation was gathering, shouted at some, made terrifying rushes at others, and set the rest laughing with silly and dirty ramblings. The respectable wanted to bind her with ropes, but the vicar forbade unkindness and urged them to bind her with compassion by praying to the Virgin and to Henry. She waited quietly in a corner and slipped home afterwards. She raved again at midday but improved, and she was composed and sane on the third day.’

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