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Chemical Control or Therapeutic Intervention?: Drugs and the Treatment of Suicidal Lunatics in Late Nineteenth-Century England.

Introduction

The foundation of the nineteenth-century public asylum rested on its responsibility to provide cure and custody in equal measure. However, in the years following the 1845 Lunatic Asylums Act, which made the erection of county asylums compulsory in England, there were a series of significant developments in both the operation of the institution and the treatment methods it adopted. The first of these was the abolition of mechanical restraint in favour of therapeutic endeavours aimed at restoring the patient to health. Alongside non-restraint was a dramatic explosion in the patient population which left nineteenth-century asylums under-staffed, overwhelmed by chronic cases and increasingly incapable of containing the violent and destructive behaviour of suicidal patients. Changes to the asylum's structure and operational environment caused alienists' initial intentions to falter.[1] What was conceived in theory, based on small-sized asylums, proved unrealistic when practised in the vast institutions that subsequently emerged. Medical superintendents came to accept that the asylum's primary responsibility had changed; out of circumstances and necessity, alienists resigned themselves to the pursuit of custodial containment. By the latter stages of the nineteenth century, these conditions proved the catalyst for an increased reliance upon the use of sedatives and narcotics to control those patients most at risk of inflicting self-injury or acts of 'self-destruction'. Chemical restraint was seen as the natural successor to mechanical coercion. Unlike chains and fetters, the introduction of drugs could masquerade behind a therapeutic rationale, making it acceptable to the emerging psychiatric profession, the Lunacy Commission and wider society.[2]

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[1] Alienist was the nineteenth century term for psychiatrist. Medical men specialising in the treatment of mental illness preferred this title as it disassociated them from the negative connotations of the 'mad-doctor'. Throughout this article the term alienist will refer to the medical men who cared for, and treated, insane persons.

[2] It is acknowledged that psychiatry was not a recognised term in the nineteenth century and that psychological medicine was frequently used to describe the study and practice of insanity. To avoid confusion over the use of terminology from this point on the word psychiatry will be adopted when referring to the medical specialty that dealt with mental illness. The Lunacy Commission was established

This article will consider whether chemical restraint flourished in the late-nineteenth century as a means of re-asserting control and prevention over suicidal patients or was based upon a rationale to provide medicinal and therapeutic benefit. In violent and suicidal cases an element of restraint remained necessary and it seemed that chemical restraint offered a less overtly forcible approach. For some alienists this was a questionable alternative; was there truly any difference between restraining a patient with sedation or the imposition of shackles? To establish an answer, contemporary attitudes to the use of drugs in suicidal cases and the level of improvement that was derived from their administration will be examined.

Historiographical Context

In their work about the 'hidden history' of drug treatment, Toine Pieters and Stephen Snelders state that 'whether to sedate or to cure…the consumption of psychoactive drugs has been an integral part of the politics of mental illness'.[3] Drugs such as morphine, opium and chloral hydrate, were important yet controversial 'medical' interventions in the treatment of insanity. Throughout the nineteenth century, alienists and practitioners were engaged in a continuous debate about the benefits and dangers of using narcotics and sedatives. During this period there were wide debates within government and the medical profession about the efficacy and safety of drugs. Both parties were increasingly trying to differentiate between medical and non-medical use and to prohibit the sale of opium. Ironically, part of their concern centred on whether opium and cannabis caused insanity.[4]

At the beginning of the nineteenth century doctors did not view opium as dangerous, but rather as 'central to medicine, a medicament of surpassing usefulness'.[5] Virginia Berridge argues that the drug's stimulant properties were isolated from medical practice and

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under the 1845 Lunatic Asylums Act. The inspectorate was responsible for monitoring lunacy provision for all insane paupers except Chancery lunatics. The Commission made annual visits to county asylums, workhouses, single patients, and licensed madhouses.

[3] Toine Pieters and Stephen Snelders, 'Mental Ills and the 'Hidden History' of Drug Treatment Practices' in Marijke Gijswijt-Hofstra, Harry Oasterhuis, Joost Vijsclaar and Hugh Freeman (eds.) *Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam: Amsterdam University Press, 2005), pp 381-395.

[4] This was a particularly tense debate in colonial settings like India. Cannabis use in India is examined in James H. Mills, *Cannabis Britannica. Empire, Trade and Prohibition 1800-1928* (Oxford: Oxford University Press, 2003).

[5] Virginia Berridge and Griffith Edwards, *Opium and the People. Opiate Use in Nineteenth-Century England* (London and New York: Allen Lane/St Martins Press, 1981), preface xxv.

reserved 'for exceptional, non-medical circumstances'.[6] It was opium's narcotic effect that was perceived as having significant medical value. Even if opium was not 'the cure-all which its most strenuous advocates saw it as', it was considered capable of providing relief from pain and a period of respite which could aid patient recovery.[7] Eminent alienist Henry Maudsley acknowledged that little was known about how and why opium was effective in the treatment of insanity. However, he still recommended its use because the sleeplessness and 'strange feelings of alarm' which often preceded insanity could be eased by the administration of opium.[8]

Similar discourse surrounded the use of cannabis in the treatment of mental illness. During the mid-nineteenth century doctors were keen to explore the relationship between madness and cannabis, particularly the idea that cannabis induced rather than cured insanity. James Mills examines this debate within the context of colonial India. He details the work of Mordecai Cubitt Cooke, a teacher turned curator at the India Museum, who studied sleep and the intoxicants used to induce it. Cooke's research revealed that 'the incautious use of hemp is…noticed as leading to, or ending in, insanity'.[9] His findings inferred that the most common cause of the mental problems experienced by patients was cannabis use. Mills contests this conclusion because the connection doctors and asylum staff made between insanity and the use of hemp was often tenuous and not scientific.[10]

The pros and cons of drug treatment, particularly its use to control patient behaviour, are debated within both the history of drugs and the history of psychiatry. Tension surrounds the efficacy of drugs and the potential abuse of their sedative properties. Drug treatment in the asylum has been viewed negatively by some historians of psychiatry and institutionalisation.[11] This stems from the perception that drug treatment was primarily employed to make patients more amenable and establish quiet in the wards of the

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[6] Ibid., 65.
[7] Ibid., 66.
[8] Henry Maudsley, 'On Opium in the Treatment of Insanity', *The Practitioner* 2 (1890), 1-8. Henry Maudsley was a prominent alienist in the last third of the nineteenth-century. He spent three years as superintendent of the Manchester Royal Lunatic Asylum (1858-1861) and later became editor of the Journal of Mental Science and president of the Medico-Psychological Association.
[9] Cited in Mills, Cannabis Britannica, 79.
[10] Ibid., 85-87.
[11] Andrew Scull, *The Most Solitary of Afflictions. Madness and Society in Britain, 1700-1900* (New Haven and London: Yale University, 1993), pp 289-291; Phil Fennel, *Treatment without Consent. Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London and New York: Routledge, 1996),p. 47; Mark Finnane, *Insanity and the Insane in Post-Famine Irelan*d (London: Croom Helm, 1981), pp 202-204.

institution. This article explores that premise and demonstrates that drug treatment was ostensibly used to overcome suicidal patients' loss of self-control by means of external intervention. In this context, the leading objective was usually the sedation of patients to maintain order and help attendants to manage the increasing number of insane persons in their care.

Attitudes and responses to self-destruction are central to the history of suicide. Acts of suicide and suicidal behaviour are defined in religious, social and medical terms. Michael MacDonald and Terence Murphy's work, Sleepless Souls, acknowledges that in Western culture suicide has been commonly viewed as 'the negation of the good death'.[12] However, as socio-economic and cultural changes have taken place, the circumstances of individual lives and the criteria that determine states of happiness and misery have been reshaped. This sparked significant changes in attitudes and responses to suicide, which fluctuated 'strikingly from tolerance to severity and back again to tolerance over the last two thousand years'.[13]

By the second half of the eighteenth century enlightened laymen and philosophers had cultivated a greater leniency and tolerance towards the act of suicide.[14] Enlightened laymen were increasingly of the opinion that 'suicide was the consequence of individual pathology'.[15] At the close of the century suicide was relatively free from religious condemnation, but the act's shock value had not diminished. In consequence, 'psychiatry was invited to take charge of it, [suicide] since society still regarded it as a threat to the established order'.[16] The connection made between insanity and suicide raised a question that dominated medical debate and divided the opinion of alienists: 'How far insanity is responsible for the suicide which occurs among a people is, and must ever remain, a vexed question'.[17] Some alienists thought 'that all who commit suicide are insane, others that delusion must be ascertained before we can pronounce any suicidal patient to be

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[12] Michael MacDonald and Terence Murphy, *Sleepless Souls. Suicide in Early Modern England* (Oxford: Clarendon Press, 1990), p. 2.
[13] Ibid.
[14] M. MacDonald, 'Suicidal Behaviour: social section', in R. Porter and G.E. Berrios (eds) *A History of Clinical Psychiatry* (London: 1995), pp 627-628.
[15] Ibid., 628.
[16] G. Lanteri-Laura and L. Del Psitoia, 'Structural analysis of suicidal behaviour', *Social Research* 37 (1970), 324-325.
[17] S.A.K Strahan, Suicide and Insanity. *A Psychological and Sociological Study* (London: Swan, Sonnenschein, & Co , 1893),p. 92. Strahan was a barrister-at-law and a member of the Medico-Psychological Association.

found of unsound mind'.[18] The notion that all suicides were insane had been largely dispelled by the late-nineteenth century. A multitude of social causes were acknowledged alongside the traditional model of insanity. The idea that insanity was not the cause of suicide per se prevailed because it allowed psychiatry to define and take ownership of suicide as both a medical and social problem. John Weaver and David Wright assert that in the hands of alienists 'suicidality became a pathological symptom of ill individuals, something to be identified, classified, institutionalized, and prevented'.[19] Alienists actively promoted institutional treatment and control as the most appropriate response to the dangers of suicidal behaviour.

Religious denunciations of self-destruction were not, however, completely eradicated; instead they were overshadowed by growing tolerance and public sympathy towards those who committed suicide. Olive Anderson's work on suicide reveals that 'mid-Victorian Londoners were conditioned to see suicide as a sad ending which deserved sympathy and forgiveness'. Anderson argues that attitudes to suicide are closely related not only with ideas about death, but also 'beliefs about the probable consequences of sickness and stress of body and mind'.[20] Although traditional interpretations of suicide adjusted during the Victorian and Edwardian period, suicide was still not perceived as a morally neutral act.

The catalysts for increased drug use

The burgeoning patient population and increased dependency on the skills of asylum attendants gradually compromised the ideal of non-restraint and made the regulation of suicidal behaviour increasingly complex.[21] Underpinning the very essence of the non-restraint system was the need for unrelenting watchful, preventative, almost parental, observation of patients. This demanded a labour intensive style of asylum management. Non-restraint was developed by practitioners but it was asylum attendants who had to deal directly with the destructive and violent behaviour of suicidal patients, and they did so in a pragmatic way. Under the system of non-restraint, the management and treatment

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[18] George Fielding Blandford, *Insanity and it Treatment: Lectures on the Treatment, Medical and Legal, of Insane Patients* (London: Simpkin Marshall, 1877), p. 191.
[19] John Weaver and David Wright (eds.), *Histories of Suicide: International Perspectives on Self-Destruction in the Modern World* (Toronto: University of Toronto, 2009), p. 4.
[20] Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), p. 191.
[21] For a detailed discussion of the rise and growth of nineteenth-century public asylums see Andrew Scull, *Museums of Madness:The Social Organisation of Insanity in Nineteenth-Century England* (London: Palgrave Macmillan, 1979).

of suicidal patients became a more practical, hands-on task, that hinged on the vigilance and skills of an under-resourced body of asylum staff.

A low number of attendants, usually one per ward, and the failure in many asylums to provide sufficient night staff were intrinsically connected to the pursuit of economy. Economic concerns contributed to the custodial character of public asylums and encouraged the increased use of drugs to control patients as a substitute for attendants. Local authorities were unwilling to spend extravagant amounts on pauper lunatics; they strove to keep the costs of institutionalisation low. Medical superintendents were charged with managing an efficient micro-economy that maximized the asylum's income. Their performance was judged on the successful control of expenditure as well as their medical contribution. Cost considerations figured extensively in the asylum authorities' decision to admit patients and recruit staff. Asylums were never rich in finances or resources and the failure of alienists to achieve high cure rates discouraged future investment and allowed economy to prevail. Moderate funds ensured that the asylum could only achieve a minimum level of care.

The asylum's impending drift toward regimentation and routine was equally detrimental to the practice of 'moral treatment'.[22] Moral treatment emphasized the notion of a free, rational, self-determining individual who could be roused to regain self-esteem and a desire to return to 'normal' life. It required patients and attendants to actively contribute to the recapture of reason and restoration of 'a healthful equilibrium in patients' lives'.[23] This approach would minimize patients' vulnerability to future mental imbalance. It was to be achieved by psychological techniques that directly targeted the patient's mind. Self-control and reason were to be strengthened through the activities of employment, recreation, religion and the intensification of personal contact between the patient and asylum staff.

Unfortunately, the high patient to staff ratio meant medical superintendents found it increasingly difficult to maintain regular contact with patients and keep abreast of individual cases. A comprehensive knowledge of patients was sacrificed with the

[22] Moral treatment recognised the lunatic as a moral subject who could be restored to reason via therapeutic, non-medical, methods of treatment.
[23] MacKenzie, Charlotte, *Psychiatry for the Rich. A History of Ticehurst Private Asylum, 1792-1917* (London: Routledge, 1992), p. 27.

emergence of 'moral management'. Anne Digby argues that 'to a much greater extent the patient was slotted into a fixed environment rather than a social context being created for the individual'.[24] Moral management evolved from moral treatment but it was laden with the connotation of a more systematic and regulated organisation of patient lives by institutional authority and rules. Individualized treatment, informed by good patient knowledge, was sacrificed with the emergence of an overtly rigid routine that expected patients to obey bureaucratic rules rather than those which aided their recovery.

In *History of Madness*, Michel Foucault is highly critical of moral treatment and its proponents. He views it as 'an operation, or rather a whole series of operations that silently organized the world of the asylum, the methods of cure, and the concrete experience of madness'.[25] A moral milieu was imposed in which, according to Foucault, the 'patient was maintained in a state of perpetual unease'.[26] This assessment fails to acknowledge the professed intentions of those who practised moral treatment. Foucault overlooks the curative benefits that could be derived from patient employment. By imposing his own schematic arguments, Foucault does not recognize that work often assisted the patient's rehabilitation, distracted the minds of lunatics, and fostered self-control, all of which were vital prerequisites for the patient's recovery.

Non-restraint and moral treatment exerted considerable influence over asylum practice, but they should be perceived as secondary contributors in the emergence of extensive drug treatment. Overcrowding of large-scale institutions was the underlying catalyst for the shift from cure to custody and, as a bi-product, the increased use of drugs in the treatment of the insane. In his study of insanity in Ireland, Mark Finnane states that the medical superintendent was responsible for maintaining order in a large institution. In light of this responsibility the treatment methods adopted were often in 'danger of becoming punishment or of simply maintaining the peace by any means possible'.[27] By the latter stages of the nineteenth century, drugs were increasingly regarded as an indispensable aid in the pursuit of peace and order.

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[24] Anne Digby, *Madness, Morality and Medicine. A Study of the York Retreat, 1796-1914* (London: Cambridge University Press, 1985), p. 76.
[25] Michel Foucault, *The History of Madness* (London and New York: Routledge, 2006), p. 481.
[26] Ibid., 483.
[27] Finnane, *Insanity and the Insane*, p. 202.

A substantial number of asylum admissions remained as long-stay patients, rapidly filling the asylum with an overwhelming population of incurable lunatics. This trend forced medical superintendents to re-evaluate and adjust their approach to patient care in light of the practical realities they faced. The innovation promised by moral treatment and non-restraint was replaced by a period of stagnation that stifled hopes of recovery and cure. Andrew Scull draws attention to the Lunacy Commission's adoption of a 'conservative criteria' on which they judged an asylum's effectiveness. He argues that their vision of a model institution was 'one where there was the greatest attention to economy, the fewest accidents, suicides, and escapes, and the lowest annual mortality rate'.[28] Within these 'cocoons of dullness' alienists aspired to provide custodial care in a sterile protective environment.[29] The asylum's operational objective became the maintenance of discipline and order. Scull's critical perspective echoes that of Foucault, who asserts that the asylum gave madness semi-liberty in a closed world rather than complete liberation. Foucault states that the asylum was 'not a free realm of observation, diagnosis, and therapeutics; it is a juridical space where one is accused, judged, and condemned'.[30] Foucault's position rules out the possibility of a benevolent, or even rational, intervention by alienists and asylum staff. The asylum is interpreted as a tool of repression that exerted discipline and control over the lives of patients. The use of drugs, to subdue outbursts of disturbed or destructive behaviour by short-term sedation, supports Foucault's argument that confinement aimed to contain and control patients by means of surveillance, restriction, and judgement.

Contemporary opinion and debate

Throughout the 1860s and 1870s, drugs became a more appealing 'medical treatment'. Bromide of potassium, chloral hydrate, digitalis, morphia, and opium were the most commonly employed sedatives and narcotics. Opinions were divided about the efficacy and motivation for their use in the general treatment of insanity and suicidal patients. Maudsley gave reference, in his work *The Pathology of Mind*, to the level of division that existed among his contemporaries:

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[28] Scull, *The Most Solitary of Afflictions*, p. 306.
[29] Ibid.
[30] Michel Foucault, M*adness and Civilization. A History of Insanity in the Age of Reason* (London: Tavistock Publications, 1967), p. 269.

> Opinion is yet divided as to the value of this [chloral hydrate] and other sedatives, and while one physician at the head of a large asylum denounces them earnestly, another who has had as large a field of practice cannot speak too well of them.[31]

Without a consensus of opinion it was exceptionally difficult to 'dogmatize upon the good effected by pharmaceutical remedies'.[32] Much of the discourse surrounding 'chemical restraint' hinged on what prompted the administration of drugs. Sedation was considered acceptable if given with the intention of subduing a violent or suicidal patient for their own and others' benefit, but it was unjustifiable if prescribed on a routine basis with the sole objective to make the attendant's task easier.

Although medical superintendents had to record the use of drugs in patient case notes, it remains difficult to determine from these entries whether medical or punitive reasons were the main motivating factors.[33] Steven Cherry shares this opinion in his discussion of drug treatment at the Norfolk Lunatic Asylum. He acknowledges that 'evidence concerning their [drugs] use or dosages is limited'.[34] Digby also concludes that it is often difficult to fully determine whether medical treatments 'recorded in patient's case histories were designed to cure physical illness, to improve general bodily health or to apply physiological remedies to treat…organic causes of mental disease'.[35] The content of patient case books allows an understanding to develop of the treatment methods and prevention strategies that were prescribed for suicidal patients, but the motivation for their use is far less apparent. In most instances, case note entries are characterized by brief and periodic summaries of the patient's progress and the medical interventions administered. Case notes were of course written for medical staff, not for historians and the purposes of academic research. Their value as an historical source must therefore take account of the deficiencies they contain.[36]

Alienists' lack of knowledge about the medicinal and therapeutic value of drugs was evident throughout contemporary discourse. Maudsley was acutely aware that alienists

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[31] Henry Maudsley, *The Pathology of Mind* (London: Macmillan, 1879), p. 551.
[32] Daniel Hack Tuke, *Chapters in the History of the Insane* (London: Kegan Paul, 1882), pp 486-487.
[33] The Lunacy Commission dictated that all asylums should keep a record of medical treatment, including drugs, and mechanical restraint. The records were examined during the Commissions annual visit.
[34] Steven Cherry, *Mental Health Care in Modern England The Norfolk Lunatic Asylum/St Andrew's Hospital c.1810-1998* (Suffolk: The Boydell Press, 2003), p. 92.
[35] Digby, *Madness, Morality and Medicine*, p. 123.
[36] For a detailed discussion of how and why case notes were produced, and how they can be used by historians see Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experiences of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine* 11, at 255-281.

needed exact information about the benefits of drug treatment. Thomas Clouston, medical superintendent of the Cumberland and Westmoreland Asylum, shared this opinion. He undertook observations and experiments on the use of opium and bromide of potassium in 51 cases of curable and incurable conditions. He declared that:

> At best we can only work very empirically. But our empiricism may be founded on a rational and scientific examination of the effects of the drugs we use…the following observations were undertaken almost entirely with the view of obtaining a little more accuracy in my knowledge of the effects of certain medicines.[37]

Clouston's findings suggested that when bromide and cannabis indica were combined it produced good effects on the patient's condition by the end of the first day of its use. He noted that patients commonly became less restless, violence abated and they slept more easily at night.[38]

The psychiatric profession had yet to develop a detailed and extensive knowledge of the effect drugs had on insanity. Only limited investigations had been conducted on the level of improvement that was derived directly from sedatives and narcotics. What then did alienists hope to achieve by using drugs in the treatment of suicidal lunatics? To pursue this question it is first necessary to consider the unique challenges suicidal patients presented to asylum staff. Suicidal lunatics experienced mood changes, sudden shifts in behaviour, restlessness, and poor sleep habits which made their conduct unpredictable, dangerous and difficult to manage. Admission documents frequently cite attempted suicide, threats of self-destruction and violent behaviour as precursors to committal. Evidence of suicidal ideation was given notable consideration at the point of admission. This was because Poor Law and asylum officials were aware that if a person contemplated suicide then intent was clearly present in the mind and eventually this could be manifest in an actual suicide attempt.

The danger posed by melancholic patients was perceived by alienists to be greater than those labouring under most other forms of insanity. In 1887, 59.6 per cent of suicidal

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[37] Thomas S. Clouston, 'On the Use of Certain Drugs in Insanity', *The British and Foreign Medico-Chirurgical Review* 46 (1870), at 493.
[38] Thomas S Clouston, 'Observations and Experiments in the Use of Opium, Bromide of Potassium and Cannabis Indica in Insanity', *The British and Foreign Medical-Chirurgical Review* 47 (1871), at 205-206.

patients admitted into asylums were afflicted with melancholia.[39] Depression, delusions and a growing disdain for life pushed a large number of melancholic patients towards suicide as the lesser of two evils. When the mind was absorbed in an intense depression, a dangerous propensity often pre-occupied the patient's thoughts and so 'he prefers severing the thread of life, to the endurance of its misery'.[40] Patients afflicted with mania sought death as an escape from the pain of insanity rather than 'moral impressions' and a general weariness of life. Unlike the melancholic who planned and carefully chose his method, patients afflicted with mania were inclined to grasp the most readily available means when the impulse struck. The patient experienced fluctuations in mood and behaviour that made observation, even for the most practised attendants, difficult to ensure. Whether melancholic or maniacal, suicidal lunatics required higher levels of care that aimed to counteract dangerous and often unpredictable behaviour. This placed a considerable strain on the asylum's human resources and made the administration of drugs, as a disciplinary tool, more appealing.

In the debate that surrounded drug treatment alienists focused on the procurement of sleep and the attainment of quieter wards as the underpinning justification and intention of drug treatment. This was exemplified in the work of Joseph Williams, published in 1845, entitled *An Essay on the Use of Narcotics and other Remedial Agents Calculated to Procure Sleep in the Treatment of Insanity*.[41] Rather than specifically targeting the mental affliction, it was intended that drugs would subdue the restless and violent physical manifestations of the illness. This allowed the patient's bodily and general health to improve and cure to hopefully follow.[42] Care and control were after all two sides of the same coin since calm patients were a necessary prerequisite to the beneficial administration of therapeutic treatments. For many late nineteenth-century commentators, control was an inherent element of care; the two were not mutually exclusive but co-dependent in the treatment of the insane, particularly those disposed to suicide. The use of drug treatment was

[39] Daniel Hack Tuke, *A Dictionary of Psychological Medicine* (London: J & A Churchill, 1892), p. 1229. The number of suicidal patients with mania was 20 per cent and a lowly 16 per cent suffered from dementia.
[40] John Bucknill and Daniel Hack Tuke, *A Manual of Psychological of Medicine* (Philadelphia: Blanchard and Lea, 1858), p. 201.
[41] John Williams, *An Essay on the Use of Narcotics and other Remedial Agents Calculated to Procure Sleep in the Treatment of Insanity* (London: J. Churchill, 1845).
[42] When patients were discharged from an asylum they were commonly classified as cured, relieved, recovered, or unimproved. Precisely how medical superintendents differentiated the application of each label is neither consistent nor resoundingly clear in case histories; some patients were simply 'discharged'. Cure or recovery was achieved when the patient was fully competent to fulfil his common duties, or was restored to the state he was in prior to his attack of insanity. Central to the definition of 'recovered' was the patient's ability to resume his former role in society based on active economic and social participation.

motivated by one of three possibilities: (1) chemical control; (2) therapeutic intervention; (3) a combination of the two. The treatment methods alienists adopted were driven as much by the desire, and increasing necessity, to maintain order as well as to effect cure.

Sedatives and narcotics, such as opium and chloral hydrate, were utilized to maintain order in the wards of the asylum as mechanical restraint had previously done. According to Lauder Lindsay 'if a superintendent administer [sic] morphia, or any other preparation of opium largely, he may boast of his rare cases of mechanical restraint and seclusion'.[43] Chloral hydrate and opium were intended to quieten restless patients and induce sleep. They were considered particularly effective in producing a quiet ward at night. This was a crucial time period in the care of the suicidal because the maintenance of adequate surveillance was compromised by insufficient staffing levels. Observed during the night by a small number of attendants and his mind unoccupied, the patient was deemed more likely to fixate on thoughts of suicide and find cunning ways of inflicting self-injury or destruction. This period of time caused considerable anxiety for attendants and received significant attention from alienists and the Lunacy Commission. The Commission was aware of the increased risk and discussed how to adequately staff wards at night time. Provision varied across the asylum system and rarely met with the expectations and requirements of the Lunacy Commission. 'On duty at night are eight men and thirteen women, which is by no means a strong staff for so large an asylum' as Colney Hatch.[44] Equal criticism was levelled at Staffordshire County Asylum, where in 1877, 'no system of special night supervision for suicidal patients exists and it seems doubtful…one can be arranged unless wards are built for the purpose'.[45]

Chloral hydrate was the sedative of choice for patients disposed to restless nights. Daniel Hack Tuke stated that alienists employed it without discrimination because it was 'regarded as a talisman in insomnia and excitement'.[46] For a brief period, chloral hydrate was 'the spoilt child of psychological medicine'.[47] It was routinely prescribed as a natural course of treatment when patients were unable to sleep. Chloral hydrate was administered to Martha Widdowson, a patient at Leicestershire County Asylum, in an

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[43] William Lauder Lindsay, 'The Theory and Practice of Non-Restraint', *Edinburgh Medical Journal*, 23 (1878), at 1095.
[44] Richard Hunter and Ida Macalpine, *Psychiatry for the Poor. 1851 Colney Hatch Asylum: Friern Hospital 1973* (London, 1974), p.103.
[45] SCRO, Q/Alc/1/2/3-16, Staffordshire County Lunatic Asylum Annual Report (1877).
[46] Hack Tuke, *Chapters in the History*, p. 486.
[47] Ibid.

effort to overcome the difficult behaviour she displayed during the night. She was admitted to the asylum in January 1875 as a 'case of melancholia with a suicidal tendency'. Observations of her behaviour revealed that 'the appetite is very poor and the patient is very restless at night'. In consequence of her restlessness it was considered necessary to prescribe a 'chloral draught every night'. Martha responded well to the treatment; she slept better and her appetite improved.[48]

Similar behaviour prompted the use of chloral hydrate in another case at Leicestershire Asylum. Mary Sutton was admitted in December 1870 suffering from melancholia with a suicidal predisposition; 'she had attempted self-destruction by taking poison before admission'. Mary was repeatedly 'sleepless at night and disturbs the other patients'. To counteract her behaviour, chloral hydrate was regularly administered at night and she 'improved considerably under its use'.[49] Selina Bloomfield was committed to Warwickshire County Asylum in October 1870 in a 'low and desponding' state. She had 'attempted to hang herself' and asked 'for poisons to destroy her life'. Selina experienced difficulty sleeping and was 'ordered Chloral 3g at night'. The chloral proved effective and it was recorded that she 'sleeps well now'. The medical superintendent instructed that attendants 'diminish the Chloral and in a few days stop it altogether'.[50]

The procurement of additional sleep was explicit in two further cases at Warwickshire County Asylum. Ann Marriott was labelled as suicidal when committed to the asylum in July 1875. The first entry in her case notes recorded that she 'has been exceedingly restless ever since admission'. During her first night in the asylum she 'slept 6 hours, 2nd [night] 4 hours'. A draught of chloral and hyoscyamine was given to calm the patient and induce sleep.[51] Admitted to Warwickshire in July 1875, Sarah Lyon 'had 5 or 6 hours sleep each night with Chloral'. She continued to take Chloral until she was discharged in January 1876.[52] Despite a marked improvement in the condition of each of these women, the use of chloral hydrate was initiated primarily to induce sleep and subdue difficult behaviour rather than provide any overt therapeutic benefit. Chloral hydrate was used on a relatively extensive scale throughout public, and some private, asylums. In her study of

[48] LCRO, DE3533/194, Male and Female Casebook, August 1873-April 1877, (admitted 30 January 1875).
[49] LCRO, DE3533/193, Male and Female Casebook, January 1870-August 1873 (admitted 20 December 1870).
[50] WCRO, CR1664/622, Male and Female Casebook, 1870-1872 (admitted 31 October 1870).
[51] WCRO, CR1664/623, Male and Female Casebook, 1872-1875 (admitted 9 July 1875).
[52] Ibid.

the privately run York Retreat, Digby argues that during the 1870s and 1880s chloral or chloral with bromide was used on an extensive scale. Her argument is strengthened by evidence from a patient who stated that chloral was used 'to quench the poor sufferers into quietness'.[53]

Advocates of drug treatment rested much of their argument on the ability to procure sleep thereby relieving the pressure placed on night attendants. When sedatives and narcotics were administered for this purpose they were perceived as assisting suicide prevention, but for Maudsley, the grounds of justification were not so black and white. He questioned the true benefit of narcotic-induced sleep when compared to natural sleep. The two were considered very different conditions, leading Maudsley to declare that, 'what is wanting is the knowledge that in either of these or other artificial states the same sort of repair and restoration of nerve-element takes place which takes place in natural sleep'.[54] By inferring that the patient gained little curative benefit from drug-induced sleep, Maudsley challenged the therapeutic grounds on which some alienists sought to legitimize their use of drugs. It is logical to conclude that the one major benefit sleep provided, whether natural or narcotic, was temporary respite from the patient's despondent thoughts or delusions.

Without recourse to mechanical restraint, control of patients depended on close observation of their activities. This practice was extremely demanding of attendants' attention and time. Sedative induced sleep offered a practical solution that eased the burden of frequently monitoring patients. Scull concurs, arguing that the abolition of mechanical restraint prompted a significant increase in the use of drugs to tranquillise patients and produce sleep. He states that if vast institutions were to operate efficiently, patients had to be forced to conform to the rules of the asylum, and often this could only be elicited by manipulating the patient's behaviour. Drugs established a new level of control over patients that was portrayed by alienists as 'medical treatment'. However, Scull perceives it as a disciplinary measure intended to secure quiet wards.[55] It was the needs of the institution and its attendants that came to the fore and took precedence over those of patients; custodial rather than curative consideration dictated.

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[53] Digby, *Madness, Morality and Medicine*, p. 129.
[54] Maudsley, *The Pathology of Mind*, p. 551.
[55] Scull, *The Most Solitary of Afflictions*, p. 290.

Night time was a particularly dangerous period for suicidal patients, but it should not be perceived that the hours when they were awake were any easier. The emotional state of the patient and the intense mental suffering they experienced proved the catalyst, according to German psychiatrist Wilhelm Greisinger, to certain 'impulses and directions of the will which are manifested in external actions'.[56] The internalization of negative emotions and ideas manifested itself outwardly, in the form of hostile and destructive actions towards the individual and those around him. The behaviour of suicidal patients was dangerous and often unpredictable, but of equal concern was its impact on the quietness of the wards and the disturbance it caused to other patients. Alienists' divided loyalty to serve the needs of the institution and the patient was summarized by Dr Pritchard Davies, medical superintendent of Kent Asylum, when he wrote: 'I believe that very few medical officers used powerful drugs purely and simply as restraints, yet I am sure many used them as means of controlling, with the hope that quiet being established cure would follow'.[57]

Despite Davies' inference that the patient's condition and cure were of concern, it remained a secondary consideration that was still to be achieved by means of restraint. The primary motivation depended on the need to control demanding behaviour and violence beyond that presented by suicidal lunatics. There were different manifestations of difficult behaviour and other types of patients that may have required 'chemical control'; drug treatment was not exclusive to the management of suicidal patients. Some alienists tried to justify sedative use in this scenario as a curative aid to stifle difficult or suicidal behaviour, but for the majority of the profession it was an unconvincing argument. The underlying fact remained that sedatives, such as chloral hydrate, were used to keep turbulent patients quiet in the way mechanical restraint had previously done. Phil Fennell argues that contemporary discourse on drug treatment in the 1880s and 1890s 'reveals the importance of drugs as a vehicle of disciplinary power in institutional psychiatry'.[58] He states that 'motivation was all important' in contemporary debates about 'chemical restraint'. Finnane also concludes that the maintenance of asylum discipline featured heavily in the decision to administer drugs. He emphasizes

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[56] Wilhelm Greisinger, *Mental Pathology and Therapeutics*, translated by C. L. Robertson and J. Rutherford (London: The New Sydenham Society, 1857), p. 252.
[57] Quoted in George Savage, 'The Use of Sedatives in Insanity', *The Practitioner* xxxvii (1886), at 181.
[58] Phil Fennell, *Treatment without Consent. Law, psychiatry and the treatment of mentally disordered people since 1845*, (London and New York: Routledge), p. 37.

that medical superintendents realised drug treatment could transform a difficult and destructive lunatic into a 'useful and obliging patient'.[59]

In his discussion of the uses and abuses of sedatives, prominent alienist George Savage declared that alienists who drugged patients into submission 'were neither better nor worse than the physicians who restrained mechanically with the same object in view'.[60] Sceptics argued that drug treatment did not represent significant progression from mechanical coercion; it simply became the old enemy under a new guise hence it quickly acquired the apt label of 'chemical restraint'. Pritchard Davies believed there was very little difference 'in the reasoning which made our ancestors keep their patients quiet by means of rope and chains…and the modern practitioner's administration of powerful drugs for the same purpose'.[61] He regarded each 'period of quiet' produced by chemical restraint, as a detrimental blow 'to the already enfeebled organism' which inevitably led to its destruction.[62]

Concern about the motivation for drug treatment led many to be critical of 'chemical restraint' but not all alienists were as bleak about the efficacy of drugs. Encouraged by empirical evidence, a small number of alienists concluded that the administration of opium and morphia could deliver an improvement to the patient's condition and, on occasion, alleviate a suicidal propensity. Opium acted primarily as a tranquilliser and was administered to 'treat all those types of madness which are characterized by insomnia and restlessness'.[63] George Fielding Blandford claimed that opium 'allays the terrible feeling of depression which melancholic patients endure, especially in the morning'.[64] It often afforded only temporary relief and brought with it the danger of addiction and a loss of appetite. Despite these risks, opium was believed to be beneficial when a persistent suicidal impulse existed and the lunatic patiently planned their act of self-destruction. Maudsley noted that 'in one instance of the kind, after its use had been continued for a long time without any marked effect, the patient got quite well'.[65] Similar results were recorded for a female patient at Birmingham Borough Asylum. Susan

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[59] Finnane, *Insanity and the Insane*, p.192.
[60] Fielding Blandford, 'The Use of Sedatives in Insanity', at 181.
[61] Francis Pritchard Davies, 'Chemical Restraint and alcohol', *The Journal of Mental Science*, 26 (1881), at 526.
[62] Ibid., 530.
[63] Laurent Sueur, 'The Use of Sedatives in the Medical Treatment of Insanity in France from 1860-1870', *History of Psychiatry* 8 (1997), at 97.
[64] Fielding Blandford, *Insanity and its Treatment*, p. 439.
[65] Maudsley, 'On Opium in the Treatment of Insanity', at 5.

Prescott was admitted in May 1853 suffering from melancholia with a suicidal tendency. Described as 'discontented' and 'more and more crazy and restless at night', she was prescribed opium and hyoscyamine for a month. Following this course of treatment, she became 'much quieter in her manner…more cheerful' and her suicidal propensity receded.[66] Benjamin Rowley, a patient at Worcestershire County Asylum, also 'began to make some improvement' after taking opium.[67] He was said to be suffering from monomania of fear and had attempted suicide by poisoning and cutting his throat. Once opium was administered he began taking his food and slept much better at night.[68] In both of these cases it is difficult to categorically determine whether the patient's recovery was due to opium or other factors. To profess that opium alone was capable of removing a suicidal desire was dubious when knowledge of the treatment was in its infancy. It is, however, plausible that the tranquillising effect a large dose of opium had on the mind and body was capable of subduing suicidal thoughts and inducing sleep.[69]

The administration of morphine also appeared to act beneficially on suicidal patients. It controlled the excitement of mania, lifted the depression of melancholia and weakened delusions. Dr Seymour, physician to St George's Hospital, favoured the use of morphine acetate in the treatment of suicidal patients.[70] Over a period of seven years, Seymour tested the efficiency of acetate in eighteen cases of mania characterized by a gloomy despondency and a strong disposition to suicide. He considered 'those suicidal cases to be where the acetate is most indicated: it seems to exercise an irresistible influence over them in preventing them from doing mischief'.[71] The influence exerted presumably came from morphia's ability to allay the patient's depression and delusions, both of which acted as triggers for suicide. Seymour's confidence in morphine was undermined by the experience of Harriet Jones at Rainhill Asylum. Harriet was admitted to Rainhill in February 1851 having been diagnosed with mania. Yet strangely her case notes record that 'on admission she appeared to be suffering from great depression of spirits with a very strongly marked tendency to self-destruction'. She refused food and was found

[66] BCA, MS344/12/2, Male and Female Casebook, 1850-1855 (admitted 26 May 1853).
[67] For any asylum patient the route to recovery usually commenced with a period of notable convalescence, signs of which were marked by increased rationality and a readiness for 'normal' life as conveyed by participation in social and recreational activities. An improvement in mood and freedom from delusions were also important indicators that the patient's mental condition was improving. Patient improvement, after the administration of drugs, was judged on a slightly different criterion. Medical superintendents focused on an improved sleep pattern, the curtailment of restless behaviour and a better appetite.
[68] WRO, BA10127/15, Male and Female Casebook vol.6, May 1860-Dec 1861 (admitted 25 March 1861).
[69] Sleep was considered to be of great therapeutic benefit in itself.
[70] Seymour classified acetate as the first preparation of morphine.
[71] Cited in Williams, *An Essay on the Use of Narcotics*, p. 62.

wandering 'about the dormitory nearly the entire of the first two nights' of her confinement. In accordance with Seymour's thinking, Harriet 'was ordered…acetate of morphia every night'. In addition 'attempts were made to induce her to take beef tea'. Her condition eventually began to improve but this was not attributed to her course of morphia. It was found that she 'suffered much from accumulation of milk but on the subsidence of this she steadily and rapidly improved'.[72]

The case notes of John Waters provide further evidence that discredits the efficacy of morphine. John was admitted to Birmingham Borough Asylum in 1851. He was suffering from partial insanity of three weeks duration and was classified as 'dangerous to himself and others'. Soon after admission, John fell into a state of bewilderment and repeatedly caused 'a disturbance in the ward by getting out of bed and dragging his bedclothes about the floor'. Morphine was administered and 'kept him quiet for a few hours but he became restless afterwards'. The morphia 'having partly lost its influence' was exchanged for doses of opium. John's disruptive and excited behaviour was not overcome by morphine or opium. He only experienced 'much quieter nights' once the shower bath was regularly employed.[73] This suggests Seymour's confidence in the therapeutic benefits of morphine was a little premature.

Evidence in support of morphine is found in two cases at Warwickshire County Asylum. Mary Smith became a patient in April 1857 having shown symptoms of an 'unnatural depression' and attempting 'to cut her throat with a razor'. Her mental condition improved but 'ever since her residence in the asylum [she] has been in the habit of taking at night the solution of acetate of morphia'. Mary took dosages 'in half and sometimes quarter of a grain'. She was unable to sleep without it but over a period of time the doses were gradually diminished and for several weeks she 'has merely been taking water slightly disfigured in taste with acetic acid'.[74] Sarah Walton was admitted to Warwickshire County Asylum in May 1870. She suffered from delusions and 'threatened to destroy herself'. On admission she appeared 'nervous and depressed with some excitability of manner' that was occasionally 'difficult to manage'. Several days after her admission, Sarah 'became violent was out of bed and noisy'. She 'had injection of morphia [sic] and

[72] LRO, M614 RAI/8/1, Female Casebook, January 1851-June 1853 (admitted 11 February 1851).
[73] BCA, MS344/12/2, Male and Female Casebook, 1850-1855 (admitted 10 March 1851).
[74] WCRO, CR1664/619, Male and Female Casebook, 1856-1861 (admitted 20 April 1857).

had a good night and has been quieter since'.[75] Although morphia brought some benefit, as demonstrated in the previous two cases, it should be remembered that Seymour only tested and observed the positive effects of morphine on eighteen patients. Drawing a causal link between the administration of morphine and any subsequent abatement of a suicidal desire was precarious when validated by insufficient quantitative evidence. Morphine may have offered limited therapeutic benefit to a small number of patients, but it was not a panacea for suicidal behaviour per se.

Conclusion

By the late nineteenth-century, alienists' declaration that English asylums were free from mechanical restraint was an ambiguous claim that was increasingly met with dubious acceptance. Robert Cameron, medical superintendent of the Midlothian District Asylum, encapsulated this sentiment in his article on the philosophy of restraint. He asserted that 'there is a very general impression among…the medical profession abroad that it is only by the free use of stupefying drugs that British alienists are able to dispense with the use of mechanical appliances'.[76] The use of drugs in the treatment of insanity remained largely akin to mechanical restraint; it targeted the body and not the mental affliction. Sedatives and narcotics merely restricted the potential for acts of self-destruction rather than removing the suicidal propensity by psychological and therapeutic endeavours. The potential for abuse was as latent in the administration of drugs as it had been in the shackling of patients. It remained possible for suicidal patients to be chemically restrained under the pretext of medical treatment, yet registers of restraint and seclusion presented the asylum as the very model of a therapeutic institution. J.M. Granville considered the therapeutic rationale for drug treatment to be a perversion of medical techniques. His opposition was rooted in a belief that the 'pretence of curative treatment was a sophistry' because the 'real object was to secure quiet wards'.[77]

This paradoxical situation left the majority of alienists, even by the 1880s and 1890s, to question whether putting the patient's brain into chemical restraint did him any benefit? Inadequate knowledge and empirical evidence stimulated an on-going debate about the moral and medical justification for drug treatment. Based on his own experience,

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[75] WCRO, CR1664/622, Male and Female Casebook, 1870-1872 (admitted 30 May 1870).
[76] Robert Cameron, 'The Philosophy of Restraint in the Management and Treatment of the Insane', *Journal of Mental Science* 28, (1881-1882), at 519.
[77] House of Commons, Select Committee on the Operation of the Lunacy Law, (1877), 397 (evidence of J.M. Granville) cited in Andrew Scull, *The Most Solitary of Afflictions*, p. 290.

Cameron confessed that he had 'seen no beneficial results to follow the continuous use of sedative drugs that could fairly be attributed to those drugs'.[78] Conflicting accounts and empirical evidence prevented alienists from making a direct correlation between the administration of drugs and the improved condition of suicidal patients. A lack of definitive evidence meant that the apparent therapeutic benefits presented by a small number of alienists, such as Seymour, could not be wholly disregarded. As long as the majority of the psychiatric profession failed to actively and extensively develop their knowledge via experimentation and case observation, no clear distinction could be drawn between 'chemical control' and 'therapeutic intervention'.

It was difficult for alienists (and remains the case for historians) to determine the underlying motivation for the administration of sedatives and to decide whether any improvement in the patient's condition could be directly attributed to drug treatment. The grounds of clarification were a 'grey area' but the evidence presented in this article infers that drugs were largely a vehicle of disciplinary power that allowed alienists to reassert control whilst masquerading behind a therapeutic approach that was more subtle in appearance than mechanical restraint. The justification of curative treatment was a plausible but often misleading argument as medicinal and therapeutic benefit remained secondary to institutional needs.

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