Thesis

on

Restraint

in the

Management and Treatment of the Insane.

by

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At different times and by different writers, different views have been held regarding the nature of insanity. Various definitions of the term have been framed, all more or less comprehensive, but destined to be modified or superseded by others more in accordance with the prevailing ideas of the day. It is only since advancing science has demonstrated the true connection between mind and body, and dispelled the illusionary fancies of the metaphysicians, that a rational philosophy has sprung up with regard to the nature of mental processes. The study of psychology having at length been put on a proper basis, and freed from the spiritualistic haze with which it has so long been shrouded, there is now great reason to hope that much may be accomplished in elucidating the various phenomena of mental disease. The study of insanity that is not founded on a physical basis can be of any real value in throwing light on the many phases of mental disorder, or in assisting to a knowledge of the proper method of treatment and management of the insane. This is my guiding principle in my subsequent remarks. Experience is beginning to teach that it is more futile to regard mind, as the metaphysicians do, as a fixed entity, and endeavors...
by a process of analysis to arrive at a true conception of it. This can only be attained by commencing with the study of mind in its simplest manifestations, and tracing its various evolutions, until it is presented to us in its most complex form. We have no actual knowledge of the human mind in its most primitive condition, but it may be taken that man first emerged from the level of the lower animals at the time when he ceased to live in a state of isolation, and to depend for subsistence entirely on individual effort, his mental capacity having become so highly evolved as to induce him to form associations for the accomplishment of purposes which should redound to the advantage of himself and others. Association is the first essential condition of civilization and progress, and these have their origin in a more or less complete self-surrender of the individual to what is advantageous to the common weal. "Inasmuch as "a large part of the nature with which "man has to come into some sort of "harmony is not what we call physical "nature, but human nature, it is plain "that a main business of his life will "be to adjust his relations to this kind. "that he cannot help doing in the "rudest form of primitive society; the
"control of his own passions from fear or fear of his neighbors. His passion is a solid foundation of a primitive sort of social feeling. But in a higher development of his social organism his relations as a social element become much more complex and special. Sympathy with his kind and well doing for its welfare, direct or indirect, are the essential conditions of the existence and development of the more complex social organism."

"There can be no combination of men for the accomplishment of any purpose without its necessarily involving a limitation of individual liberty, and the imposition of restraint. Abstract ideas such as right and wrong, justice, re., etc. are all the outcome of man's social intercourse with his fellows, and vary in their significance according to the complexity of the relations which exist between the different units of the social organism. They have not always a uniform quantitative and qualitative value, and are devoid of meaning except when considered in connection with some social system. The same holds good with regard to insecurity, no true exception of its nature being possible except when it is viewed from a social standpoint. When a man is born he becomes a unit of

a social system, in a higher or lower state of civilization, and is endowed with certain natural aptitudes to conform more or less completely to the essential conditions of that system. The degree to which he can discharge his functions as a social unit will depend entirely on his original mental capacity, or upon that as influenced by education, or modified by disease or injury. To my mind it would be a philosophical view of sanity to regard it as a relative condition, taking as its measure the degree to which the individual, by virtue of inherent qualities of mind, is fitted to conform to the essential conditions of the social system of which he forms an integral part.

Most certainly it is that no real separation can be made between sanity and insanity; the one merges into the other, and no line can be chalked out there all on one side are sane and all on the other insane. Any attempt to do so must end in failure, and this should be borne in mind by those who from time to time formulate definitions of insanity purporting to attain to such a consummation. For practical purposes, I admit that a line, arbitrary though it be, must be drawn somewhere and, as the question has important bearings on subsequent remarks, I shall proceed to
indicate my views as to where sanity may be considered to end and insanity begin. If the individual can conform generally to the essential requirements of the social organization of which he is a part, he may, broadly speaking, and for all practical purposes, be regarded as sane. If he cannot so conform without the aid of external restraint, or the operation of the penal code, then I consider he may truly be regarded as insane. This view of insanity, I am aware, is widely different from what is recognized as insanity by the English law. The law makes a marked distinction between crime and madness, which I believe is founded on a misconception of what madness really is. The more I have studied the subject the more is the conviction forced upon me that criminally cannot exist apart from insanity, and that crime is merely one of its outward manifestations. It does not however necessarily follow that because a man who commits a criminal act is insane, he is therefore irresponsible and ought not to be punished. The question in criminal cases when a plea of insanity is urged is attenuation or exacerbation of the offence, ought to be, not the determination of the existence of insanity in the criminal, but its degree, and punishment should be meted out in proportion as it is considered such pun-
ishment is calculated to induce a healthier frame of mind in the individual, and prevent the recurrence of such offenses. It may be well in this connection to explain that punishment, whatever be the form it takes, or in what cases it be applied, should always be a mode of treatment and not an act of social vengeance. While doing this as an example to others, it should never be lost sight of that its main object should be to act as a restraining influence, or a counterforce, to guide the individual into healthy modes of thought and action, and to fit him as far as possible to take his proper place in the social organism. It is not an unreasonable question to ask whether the sanction of capital punishment by law is not a relic of a barbarous age, and an anachronism in our more enlightened knowledge of the laws that regulate human thought and action. That there is an intimate relation between crime and insanity, no one who has studied the subject will dispute. As in insanity, so in criminality, there is every possible degree. Maindlay divides criminals into three principal classes:

"(a) The first class, consisting of those who, not being really criminally disposed, have fallen in consequence of the extraordinary pressure of exceptionally adverse circumstances;"
(b) The second class, of those who, having some degree of criminal disposition, might still have been saved from crime had they had the advantages of a fair education and of propitious conditions of life, instead of the disadvantages of an evil education and criminal surroundings;

(c) The third class, I born criminals, whose instincts urge them blindly into criminal activity, whatever their circumstances of life, and whom neither kindness, nor instruction, nor punishment will reform. They returning natural, all to crime when their sentences are expired, like the dog to its vomit, or the sow to its wallowing in the mire.*

In the last two classes it will be noted that the primary cause of mental degradation lies in a radical defect of constitution, and with reference to the first class, it may be remarked, that, inasmuch as comparing few of all men are subjected to the same unfavorable influences become criminals, and as probably an equal number become insane, it may be surmised that the starting point here also is to be found in defective original capacity. Between criminals of the third class and many of our insane lunatics there is no possible distinction, and criminals of the first two classes appear to me to be merely

* Pathology of Mind p. 104.
madmen afflicted with the milder and moreenable forms of insanity. It follows therefore, that so-called criminals, no less than lunatics, should be objects rather for commiseration than for reprobation and contempt, and that there should be a greater similarity than there is at present in the modes of dealing with criminals and lunatics respectively. "These are, on the one hand, many criminals who exhibit such evident signs of defect or unsoundness of mind that it is impossible to say confidently whether they ought to be sent to an asylum or to a prison; and on the other hand, there are insane persons who, since such criminal and vicious tendencies, that one cannot help feeling that the discipline of a prison would be the best treatment for them.*

It is truly pitiable to watch the rough and ready method pursued in our Police courts in assigning to jail, it may be for the hundred and fiftieth time, some poor unfortunate individual for a repetition of a criminal offence. It has been shown beyond doubt that criminal parents are prone to begot an insane progeny, and vice versa. In studying the family history of some of the patients in the Middlesex asylum, many have struck with the pregnancy with which one or more

* Maudsley's Pathology of Mind. p. 100
members of the family belonged to the criminal class, and also with the number of cases in which the lunatic, before being conveyed to the asylum as insane, had been found or imprisoned for various offences against the law. I may here cite one out of many cases as illustration of what I have here regarded the intimate connection between criminals and lunatics, and the consequent necessity for an approximation in the modes of dealing with the two classes.

A. B., a patient in the Midlothian asylum suffering from delusional mania, has a brother J. B., who is greatly addicted to drink, and has again and again committed thefts and other criminal offences. I had frequent opportunities of seeing and conversing with J. B., and from his appearance, conversation, and general conduct, I was inwardly satisfied that he was insane, although I might have difficulty in granting a medical certificate that would satisfy the law that he was of unsound mind and a "proper person to be detained under care and treatment" as an asylum. Yet this brother J. B. lived literally half his life in jail, being liberated from time to time, only to be again apprehended and sent back. He was confined probably in an ill-lighted, ill-ventilated
cell, cold and damp perhaps, was supplied with poor food, and subjected to the rigorous discipline of the place with all its gloomy and forbidding surroundings. Contrast this with the condition of his fortunate brother who lived in the enjoyment of the comparative freedom and amenity of a normal life, with surroundings of the most pleasant description as compared with those of the other.

One of the best tests of a man's mental condition is his conduct, and not infrequently has it happened in the history of the insane that the commission of some criminal act has been the first means of drawing attention to the mental state of the culprit, he having never previously been suspected of unsoundness of mind. And it is a well-known fact that it is in the early stages of all forms of insanity that crimes are most apt to be perpetrated. It may not be out of place in this connection to ask how many human beings have been executed for murder, who, had they been allowed to live, could have ultimately become inmates of criminal asylums.

It is sad to think how many lunatics in our asylums who in the earlier stages of their insanity were confined as criminals in jail, only becoming
lunatics, and thereby entitled to the
amenities of an asylum, when their
disease had become so marked that
two medical men could off-hand detect
to their insanity after a cursory examination.
It is an axiom in the treatment of lunatics
that it is in the earlier stages of their
illness that they are most curable.
It is recommended as of great importance
that they should be removed from
familiar scenes and associations, which
in recent cases, have a powerful
tendency to produce a confirmed state
of insanity, and that, to counteract
morbil tendencies and induce healthy
action, their surroundings should be
made as agreeable as possible. It may
well be asked whether a jail is a
proper place in which to carry out
such treatment. While the jail
performs an useful function in suit-
able cases, it is plain that it is by
no means suitable for all classes of
criminals, and I take leave here to
point out that this defect is one
due entirely to the non-appreciation
of the intimate relation that exists
between crime and madness. Between
jails and asylums there is a wide
gulf which corresponds to nothing in
nature, and, as long as this exists,
these must necessarily be a class of
mentally defective beings for whose
care and cure there is no adequate
provision made.

I have endeavoured in the foregoing remarks to show that insanity must be considered not as any definite thing, but as a thing embracing a very wide range both as to degree and as to kind; that it ought philosophically to be studied from a social standpoint, insanity being regarded as a harmony with the laws of social well-being, and insanity as a discord or want of harmony with those laws. I have shown in this way the intimate correlation between criminally and insanity, and indicated in what respect I consider the treatment adopted to be defective and inconsistent. I have also endeavoured to make clear that every social organization, by virtue of its origin and existence, implies the restraint of each component unit. Restraint, then, being essential in the case of all members of society, is the more indispensable in the case of anti-social beings, if efforts are to be made at all to save society from decay. Restraint should differ rather in degree than in kind; while prison and asylum treatment meet the requirements respecting the great mass of criminals and lunatics, there is here the less an intermediate class of cases that are too hard to
be benefited by the rigours of the jail and yet not made enough for the comparative freedom from restraint enjoyed by patients in an asylum. What I wish to bring out in this connection is that there ought to be no class of restraint, but individual restraint, that systems of restraint should be graduated so as to meet the requirements of every individual case, and that in each case requiring restraint, it should be decided on its merits as to the amount and kind of restraint required.

So long as insanity exists as it is at present, so long will restraint of some kind be required, for it is plain that society has a right to subject the anti-social being to such restraining influences as are calculated to make him conform to its laws and prevent him from doing that which is detrimental to its welfare. It now remains to be considered what form such restraint should take, and to what extent it ought to be carried.

To any man who has studied the nature of the subject or is susceptible of ordinary feelings of humanity, no arguments are needed to show that it should be reduced to the lowest limit compatible with the welfare of the patient and the safety of the public. In this sense, and in this sense only, an
I am advocate of the so-called non-restrictive system. I have said that, when a man becomes so far insane as to be unfit to discharge his social obligations, he must of necessity be subjected to restraint. The manner of his disposal will naturally turn on his opulence or poverty, and on the nature of his insanity. If he is rich, he may be efficiently treated at home, or he may travel with competent attendants, or he may be sent for treatment to an asylum. If, on the other hand, he is poor, removal to an asylum is, in almost all cases, the only feasible or satisfactory expedient. It may be considered then that asylums are indispensable in the treatment of insanity. Dr. Kirkbride in his work on the construction of the Insane Organization &c. &c. Hospitals for the insane, p. 300, says—"Asylums can never be dispensed with, no matter how persistently ignorance, prejudice, or sophistry may declare to the contrary; without resorting to a greater or less extent to the conditions of a past period with all the inhumanity and barbarity connected with it. To understand what "would be the situation of a people "without hospitals for their insane, it "is only necessary to learn what their "condition was when there were none.

* Quoted by Dr. Hack Tuke M.D. in his Presidential Address delivered before the Medical Psychological Association Aug. 2nd, 1881. Vide Journal of Mental Science Oct., 1881.
I shall now proceed to treat of the various forms of restraint which are practised in domestic asylums, founding my views on the results of a long-continued experience in the management and treatment of the insane in the Midlothian District asylum and elsewhere.

For convenience I have divided the subject into the following heads:

I. Mechanical Restraint, or restraint by mechanical appliances such as camisoles, wristlets, hand-belts, muffs, crib-belts, &c.

II. Chemical Restraint, or the employment of stupefying drugs.

III. Muscular Restraint, or the employment of superior physical force at the hands of attendants.

IV. Seclusion, which means, according to the definition of the Scotch Lunacy Commissioners, putting the patient into a single room at any time between 10 A.M. and 6 P.M., alone, and with locked doors.

V. Cold Baths, Shower Baths, Cold Affusion, the Douche, &c.

VI. Punishment.

**Mechanical Restraint**.

In British asylums the routine practice of restraint by mechanical appliances such as I have enumerated alone is
reminiscence of an era in the treatment of lunatics which is now happily past, and which, let us hope, will never return. Indeed not here dwell on the horrors practiced at a time when brute force was the only treatment which ignorance and superstition could devise. Suffice it to say that within the last thirty or forty years an increased knowledge of mental disorder has affected a complete revolution, and brought with it a method of treatment at once more rational and humane. So great indeed has been the revolution of feeling in this country against restraint that there have not been wanting men who advocate a system of treatment that aims at its entire abolition. I have already alluded to the doctrine of Non-restraint and expressed my opinion as to its inapplicability except in the sense of abolishing all mischievous and unnecessary restraint. As proof that mechanical restraint is both mischievous and unnecessary, I need only contrast the condition of lunatics at the present day with what it was in former times. But it is only in this country that mechanical restraint has been entirely discarded as a general mode of treatment. The few instances of its use are almost exclusively confined to surgical cases in order to preserve the patient from
self-incurred. In my own practice I have not had occasion in any person in whose case it was necessary to address to the form of restraint except under the circumstances first alluded to, when mechanical restraint is universally admitted to be frequently required. I am convinced that this form of restraint, if not the very worst, is, at any rate, the most barbarous that can be practised. If we, as humane individuals, can imagine ourselves bound down in the position, say to a chair, or lying in a box-bed with a lid securely fastened over us, we experience the most painful feelings of restricted liberty, which come into view in practice struggles for freedom, the severity of which merely serves to intensify the mental agony. I say, if we can experience this in the abstract, we are in a position to judge of the misery which an actual experience of it is to the madman, with his greater nervous irritability and diminished self-control. Is it then surprising that to a sympathetic people like those of Great Britain, the employment of mechanical restraint, except as a last resource, should be extremely repugnant? In most of the American asylum mechanical restraint is employed to a far greater extent than in this country, and its principle is even upheld as being the best mode of dealing with a very large number of cases, Dr. John-
Gray of the Utica Asylum U.S. in his Annual Report for the Year 1881, has unequivocally defended the principle of mechanical restraint, and has laid down the following rules for its practice:

"1/ For cases of suicidal disposition
   "2/ When there is determined and persistent disposition to self-maiming, or injury, or denuding the person, or debasing self-abuse.
   "3/ When there is great destructiveness, or violence towards others."

The general conclusion of this paper is that there is no real difference in principle among experienced professional men who have devoted their lives to this specialty; that the English Commissioners of Lunacy and the Superintendents recognize the necessity of some mode of protective restraint, but having no settled convictions in favour of any particular method, they use coercive measures in the form of seclusion, the use of padded rooms, wet and dry packing, straitjackets, and manual force on attendants."

Without disputing Dr. Gray's conclusions as to the means adopted in English asylums for the purpose of avoiding mechanical restraint, I think that, *  

Regarding this mode of restraint as an
adherent expedient to be employed only
as a last resource, I need make no
apology for advocating the adoption of
some other means by which mecha-
nical restraint can be avoided. More-
over the conviction is forced upon me,
by comparing results of treatment in
dungeons conducted on the principles of
restraint, and of non-restraint, that,
the less mechanical restraint is used
the less necessity will there
be for restraint of any kind.

Chemical Restraint.

There is a very general impression among
members of the medical profession ac-
towed that it is only by the free use
of soporific drugs that British asylums
are able to dispense with the use of
mechanical appliances in the manage-
ment of the insane. It cannot be gains-
said that, by the use of soporific remedies,
soothing and quiet, the patients may be
as effectually controlled for the time
being as by any species of mecha-
nical appliance, nor can it be denied
that in many of our asylums paresitics
and sedatives are employed in such
doses, so continuously, and for such
purposes, as to warrant us in speaking
of the use of them as "Chemical Restraint."
But there are no facts to bear out the assumption that it is by excessive drugging we are enabled to avoid the use of restraining apparatus in our asylums. On the contrary, there is incontrovertible evidence to show that, in foreign asylums where mechanical restraint is largely practiced, chemical restraint is likewise employed to an extent not thought of in this country.

Dr. Hilliard has been at pains to collect statistics for purposes of comparing the relative extent to which mechanical and chemical restraint are carried in British and American asylums. The result of his investigation clearly shows that, in British asylums and in the few American asylums conducted on non-restraint principles, chemical restraint is not the substitute or alternative for mechanical restraint, but that, on the contrary, the general rule seems to be: the more mechanical restraint the more chemical restraint. He says: "On reflection this need not surprise any one. For, as one American superintendent states it, 'Rest is vital to successful treatment of acute mania.' Mechanical restraint will not suffice as it merely limits the range of muscular action, neither precludes "the patients' efforts, nor quieting the violent and exhausting action of this..."
"vocal organs. The same ingenious super-
intendent shall invent a protective
"sag and still more efficient appli-
cances of restraint, recent must be
"had to redamine drugs to secure the
"vital rest. And so the Superintendent
"writes that the narcotics he gives are
"not as substitutes for restraint but
"in some cases associated with restrai-
"ning apparatus."

I am constrained by the verdict of my
own experience to coincide with Dr. Willmott
in the views he expresses. In the midst
of them as in Chemical, is now as
obsolete as mechanical restraint.
It is little more than a year since I
have entirely discarded the employ-
ment of narcotics for purposes of re-
straint. Formerly they were used to a
considerable extent in the case of
violent and violent patients but
the experience I acquired of their effects
determined me gradually to avoid
their use. That there are indications
for the use of sedatives and narcotics in
the insane, as in the sane, every
one readily admits, and it is beyond
doubt that such remedies as chloral
muriatic &c. have their advantages when
judiciously employed. It is a terned
doubtful however whether the systematic
and indiscriminate use of toxic
remedies is ever productive of good. That in very many cases they are positive

* Notice on Chemical Restraint. See note p. 18.
and previous harm. I am quite convinced.

In late years hypogamia has been largely used as a sedative in many of our asylums. I have myself had a large experience of its use. It is a powerful drug and very reliable in its effects, producing in small doses of to or even to a grain of the extract well marked toxic symptoms of a paralytic character. Judged as a means of restraint, it has no equal in the pharmacopoeia. If chemical restraint is the employed among the insane, my experience tells me that hypogamia, especially green gambogia, is at once the safest, the quickest, and the most effectual remedy that can be used. As a curative agent I believe it is of no value. At one time I used it extensively in the case of noisy destructive and violent patients. Of its efficacy in allaying excitement there can be no question, but that it does any permanent good, except such as may be claimed as virtue of its moral influence as a form of punishment, I do not believe. I generally prepared administering it hypodermically and actually commenced with or of the extract. The effects which I noted correspond in the main with those of other observers. They were, a general relaxation of the voluntary and involuntary muscular systems with loss of control
over the bladder and rectum. Paralysis of the legs with staggering gait and ultimate inability to stand. Paralysis of the muscles of articulation with increasing difficulty, and finally complete loss of the power of speech, the phenomena being not unlike that is seen in some forms of general Paralysis. The pupils are widely dilated. The respirations become slower and deeper. There is usually great flushing of the face. The effect on the heart is very much like that produced by digitalis—the pulse beats are reduced in frequency and increased in strength and volume. The subjective symptoms are impairment of vision, a feeling of dryness and suffocation about the throat, confusion of ideas, delirium with hallucinations deepening into slumber and coma. Small doses of the drug, instead of allaying excitement, I frequently found merely added fuel to the flame. That this was due to some specific effect of the drug itself, and did not depend on any feeling on the part of the patient of some less or greater pain or suffering, is borne out by the fact that I observed the same phenomenon to follow when the drug was administered per os, without the patient's knowledge, as when it was given spontaneously. Although this drug is not without its
dangers, declare it to be very safe in comparison with such drugs as chloral, morphia, and conium. To one not accustomed to see the effects of hypogastric, the symptoms produced sometimes have a very alarming appearance, especially when the dose has been moderately large, or the patient unusually susceptible to its influence. The patient lies in a state of profound coma with swollen livid features, widely dilated pupils and slow, irregular, almost convulsive breathing. These symptoms, however, do not usually indicate any real danger to life. It must be remembered, however, that with this drug, as with most narcotics, while there is speed of tolerance established, though not to the same extent, I think, as with opium, there are on the other hand idiosyncrasies of constitution that render a moderate dose dangerous in one case which in another case would be of little avail. And this is one of the greatest objections to the use of the drug as it is indeed to the use of all narcotics. There is another consideration. The kept in view, that the effects of hypogastric vary according to the mode of its administration and to the condition of the patient. Generally a dose given subcutaneously produces as powerful an effect as twice the
quantity given by the mouth, the drug acts
more powerfully on a weak or exhausted
constitution than on a strong or healthy one,
and, when given by the mouth, the effect
is greater when the stomach is empty than
when it is full. One remarkable feature
in the effects produced by hypoglycine,
which is so manifest to everyone who
has experimented with the drug, is the
extreme repugnance with which it is re-
garded by all who have experienced its
effects.

Mr. N., a patient at the Midlothan
asylum, an intellectual though morally
degraded woman, who used to have
an occasional dose of 9 or 10 grains
administered to her subcutaneously, was sent
to declare that she had a feeling as
if her whole inside was burned up, that
her mouth and throat were parched, giving
the sensation of a ball of hair sticking
somewhere about the fauces and pre-
venting her from swallowing, that sur-
rounding objects swam before her eyes,
that she felt quite helpless to do any-
thing for herself; that she was in a
semiconscious delirium of the most in-
tense and horrible description, seeing shapes
and hearing voices that made her shudder.

Another female patient A—B—
was treated from time to time with hy-
poxyane. She suffered from suicidal
melancholia with occasional acute
paroxysms of mental agony during which
she was extremely anxious and restless, con-
tinually wringing her hands and eagerly asking for bromide, to relieve her mental distress by putting an end to her existence. The hypomania acted in the usual way giving an restless and visible sign of the impression of restoring mental tranquility. Nevertheless, the patient, so far from acquiring a liking for the drug, evinced the greatest dread of it. Sometimes, indeed, long after the drug had ceased to be given to her except at rare intervals, did she voluntarily ask for it, but, when her wish was about to be grati-
fied, her courage failed, and she shrunk back in horror, as if the sight of the drug had called up old recollections so vividly that she hesitated to choose between her present mental misery, and another ex-
perience of her former sensations under the influence of the poison.

These said enough to show that the tranquillity produced by hypomania
is apparent rather than real, and that its effects, when long continued, cannot fail to be disastrous. Its only good in lunacy practice must be sought for, not in its therapeutic, but in its restraining powers, and while it may have its advantages in certain exceptional cases, anything like a routine employ-
ment of it must be strongly condemned. I believe its administration in acute
cases, whereas recovery and indices de-
mentia, such at least has been my
experience. None of these used any
sedatives for more than a year, and
they are now practically in complete
relapse. While I admit that their
occasional use may be beneficial in
some cases, I must confess that my ex-
perience militates against the opinion
that their frequent or continued ad-
ministration is either beneficial or
necessary. I have observed that in the
middleclass asylum, excitement and
violence are now as nothing compared
with the state of matters that existed
when such drugs as chloral, atropine,
and hyoscynam were extensively used.
The reports of the Inquiry Commissioners
make repeated comments on the remark-
able freedom from excitement among
the patients. Severe cases are now
more treated with sedative drugs,
and I am satisfied that recovery is
more speedy and certain when the means
than drugging are employed for their cure.
We have in the present blind faith
in drugs as the panacea of all the
ills that flesh is heir to, but a
remnant of a barbarous superstition
that would cure an epileptic by
the burial of a live cock, or a
madman by making him drink of
the water of a so-called virtue
well.

* See *The Past in the Present* by D. Arthur Webster, pp. 265-267.
Muscular Restraint.

The part which attendants play in the treatment of lunatics is a very important one, and the value of a good staff in the hands of an asylum superintendent cannot be over-estimated. It is through their agency that it is possible to carry out the individualization of patients—an essential condition of successful moral treatment. Success in asylum practice depends in great measure on the moral influence exercised over the patients by the staff, and it is all-important that this duty should not be left in the hands of ignorant and unsympathetic persons, who, when they find themselves clothed with a little brief authority, are apt to tyrannize over their charge in a manner little conducive to the welfare of the latter. And here is the great difficulty in the treatment of the insane, which tells in an especial manner in poor asylums, where considerations of economy compel the aggregation of large numbers of lunatics. Under proper supervision, however, the ordinary class of persons who become asylum attendants can be made to understand the nature of the relation that is to subsist between them and those they control, and to discharge their obligations in a fairly satisfactory manner.
In attendants we have a potentiality for good, which, if skillfully handled, yields excellent results. It is mainly to their intelligence, tact, and judgment, guided and assisted by the higher officials, that we must look for improvement on our present mode of treating the insane. In this way we can a graduated system of control moral, and physical, be properly carried out, and in view of the fact that an aggregation of lunatics we have to do with every possible degree of mental aberration, any means by which we are enabled to meet individual requirements must be carefully fostered. By kindness and firmness on the part of the attendants, most excited patients are calmed down without there being any necessity for recourse to special restraints. But I would not advocate physical force at their hands in all cases. Their function in this respect causes when patients are so violent that attempts at personal restraints might be fraught with danger rather to patients or attendants. Most bruises and broken bones are frequent results of such encounters, the records of every asylum furnish ample proof. Struggles between patients and attendants should never be permitted to take place. They are unseemly, have a baneful influence on the other patients, and
are a fruitful cause of many deplorable accidents. Many cases of excitement occur now and again which require more than ordinary caution, everyone who has had practical experience of insanity will admit. When a patient is violent and destructive something must be done to prevent injury to self and others, and this brings me to the consideration of the next subject, viz.:

**Seclusion**

There was a time when coercion in the form of mechanical restraint and seclusion with various kinds of punishments was the chief means employed in the treatment of the insane. Seclusion has therefore become associated in our mind with a grim dam of which is now regarded by us with feelings of digestion; but we should be careful lest mere prejudice should prevail so far as to make us blind to the real merits of seclusion, and forbid its use for no better reason than that it was grossly abused in former times. I have frequently found seclusion to act in a directly beneficial manner, and I think it a pity that it should be coupled with mechanical restraint in asylum registers as if it were something of a very objectionable nature.
I may here digest to say that no just comparison can be made between the practice pursued in different asylums with regard to the use of restraint, when no cognizance is taken of the employment of stupefying drugs. Each dose of hypodermia, or chloral, or opium, or what ever remedy be given for the purpose of allaying excitement, should be entered in the Register of Restraint, not otherwise than is done when recourse is had to the carbolic, or when the patient is put into a strait jacket, or the patient is put into seclusion. Under present circumstances it is a very easy matter to paralyse a troublesome patient in an asylum by means of a powerful narcotic under the guise of medical treatment, and at the same time to present the appearance of a complete absence of restraint in the management of the institution. I am satisfied that much harm is done in this way that might be avoided, were it frankly avowed that cases occur every now and again calling for exceptional restraint, and that it should be the object of superintendents of asylums, not to make a show of being able to dispense with restraint entirely, but to endeavour to find out in what way restraint may be employed so as to be most beneficial, or it may be least injurious to the patient's welfare. Hence already stated that it is principally to the attendants we must look
if we wish to reduce restraint to a minimum, but that their control over the patient should cease at a point where danger to either party is likely to result. In many cases the patient is preceded by the patient, foreseeing the hopelessness of struggling with superior physical force, and it is this consideration that is taken into account in the stereotyped rule of asylum management that no attendant should ever, if possible, struggle single-handed with a lunatic. When a struggle is inevitable even though there be two or more attendants to cope with the lunatic, it should never be persisted in, and some other mode of restraint should be immediately adopted. The patient may be restrained by mechanical appliances, or he may be rendered powerless by har- estics; but a more humane and less dangerous method of dealing with him would be, I venture to say, to place him in seclusion. When a man is attacked with cerebral meningitis, his medical attendant recommends his being placed in a darkened room and removed from all irritating influences; and, in the case of a great number of other bodily ailments, the patient voluntarily seeks company, preferring the privacy of his own apartment. Can it be that among the absence such utterly opposite conditions,
obtain, that seclusion must in all cases be regarded as an unmitigated evil? It is in recent acute cases, where the patient cannot safely be controlled by attendants, that seclusion is of especial service. By placing the patient in seclusion in the first instance, there is afforded us an opportunity of understanding the nature of the case, which is denied by the two prevalent practice of administering sedative drugs. If paralyses are to be effective in calming excitement, they must be given freely, and it is precisely in recent cases that free dragging with such remedies is fraught with most danger. In chronic cases, on the other hand, where the patient's habits and constitution are known, it may administer narcotics, if necessary, with a comparatively easy conscience. I seldom find it necessary to resort to seclusion except in the case of recent admissions when the patient is violent and destructive, and I have almost invariably found that, after a few days' seclusion, the patient has so far settled down as to be amenable to ordinary discipline. In cases of recurrent acute mania, where excitement with violent behaviour is the outcome purely of disease, and is beyond the patient's control, I prefer resorting to seclusion rather than to any other form of restraint.
As a means of discipline in chronic cases where the patient is not entirely bereft of self-control, I regard seclusion as a clumsy and unsatisfactory expedient. For such purpose we have other and more efficacious means which I shall refer to hereafter. In many cases it is unnecessary to lock the door; the patient lies quietly in bed. Should he behave in the most violent manner of allowed to associate with the patient. This is especially noticeable in the case of epileptics. Seclusion in these cases is a positive good, whether regard be had to the patient himself, his fellow-sufferers, or his attendants.

The seclusion room should be of ample cubic capacity, well ventilated, and properly lighted if possible. A fitted room may, on rare occasions, be an advantage as being calculated more effectively to prevent self-injury. It would be well in all cases to avoid using lock and key, and, should it be essential to deprive the patient of the power of leaving his room at pleasure, an arrangement could easily be made whereby the door might be opened from without in the ordinary way, while means should be no means available to the patient of opening it from within.

This may appear to be a trivial matter in view of the fact that the end to be attained is the same whether
The means lie a key or some other contrivance. But I attach the greatest importance to every means being taken at asylums to eliminate as far as possible in the management of the patients the use of that emblem and how reminder of lost liberty and subjection—The lock and key.

Th rail, as one of the most important advances in modern lunacy practice, the system introduced some years ago by Dr. Batty Tuke, known as the Open-door system. The advantages of leaving open doors in asylums, instead of keeping the doors of the various wards jealously guarded by lock and key, are admitted by many and important from the point of view alike of patients and staff. But it has been objected by some that the system is incapable of general application, and that risks are run by asylum superintendents which they are not justified in courting.

My own experience of the Open door system which has been in full operation in the Midlothian asylum for the last two years, affords me convincing proof that nothing but good can flow from its adoption. The great advantage of the system is that it removes a form of physical restraint that is imposed on the whole asylum community merely because of the disorderly conduct of a few of their members, and substitutes a
form of restraint which can be adapted to meet the necessities of each individual case. The attendants are forced to give their constant attention to their charge with the result that excitement is very appreciably diminished and general contentment promoted. Actual experience has disproved the hypothesis that the adoption of the system would involve additional expense or be attended with a greater number of accidents and escapes; and it is now being very generally recognised by Scotch asylum superintendents that the abolition of locked doors is no more impracticable than was the abolition of walled airing courts and mechanical appliances now in use, and that the benefit arising from a more restricted use of both and key is quite as great as that which followed the disease of those other modes of restraint.

**Cold Baths &c.**

In the use of cold water we have a more powerful means of restraint - its efficacy in subduing excitement for the time being is well seen whether the patient be plunged into a cold bath, or be subjected to showering, or to cold affusion. This effect of cold water, though erroneously attributed
to some healing virtue intrinsic in the water itself, did not escape notice
in by-gone days when religious rites and superstitious and ignorant, the only reliable means
of restoring lunatics to reason. Furioso
maniaics were brought from far and
near, with much ceremony, to certain
sacred wells, the water of which they
were compelled to drink. There is a
famous well of this kind on an island
in Loch Maree, and belief in the
healing properties of its water when drunk
exists in Ross-shire to the present day.

In the accounts given of the cures effected
by drinking its water, it is amusing
and instructive to observe how essential
it was to succeed that the madman,
either before or after partaking of the sacred
water, should be subjected to repeated
immersion in the loch!*

In the River Fillan, near Tyndrum in
Perthshire, there is a large deep pool,
known as the Holy Pool, whose clear
cold waters were similarly supposed
to have curative properties, and into
which, until comparatively recent years,
lunatics brought from all parts of the
country were freely plunged. After the
lunatic was deemed to be sufficiently
soaked, and had completed the ceremony
of taking three plonges from the bottom
of the pool, and walking three times
round three cairns on its margin, dro-

* See *The Past in the Present* by Dr. William Mitchell
p. 276
a place or each, he was led off to the ruins of St. Fionnan's Chapel where he was allowed to pass the night chained to a heap of stones known as St. Fionnan's bed. 
If alive next morning, he was generally found to be restored to reason; as 
day the old Church Records, we have 
here a combination of mechanical and 
chemical restraint that, however 
efficacious in former times, can scarcely 
find favour at the present day. 
As a means of discipline especially 
in some cases of an hysterical nature, 
and I so-called moral insanity, I 
believe the cold bath does positive 
good; and thus I may whilst fully 
appreciating the jealous watchfulness 
which aims at preventing abuse of re-
straint, although perhaps, through excess 
of zeal, it may cause errors in an opposite 
direction, and hampers the original 
goal that those who have to do practically with 
the care and treatment of the insane. 
The employment of cold water, however, 
as a means of restraint, particularly 
in the form of effusion on the doctors, is 
attended with grave dangers to life, 
and it should be used with the greatest 
cautions, the more especially as its 
use is not essential, and can easily 
be dispensed with in asylun practice. 
I consider, when the employment of 
any kind of restraint, though it can 
be demonstrated in some cases to be
an actual benefit, is attended, like cold and shower baths, with serious danger, and is peculiarly liable to abuse, that it is well such method of treatment should be regarded with suspicion. As a matter of fact, I scarcely ever, in my own practice, make use of cold water restraint in any form.

Punishment.

In some, not acquainted with the nature of insanity, it may seem inhuman to speak of punishment with reference to a lunatic. They regard insanity as some definite fixed thing separated from sanity by a wide gulf necessitating an abrupt transition in our method of viewing and dealing with the two states. They look upon the infliction of punishment as an act of vengeance or retaliation, which is right and proper in the case of criminals, but highly reprehensible in the case of lunatics. I have already stated my view as to the nature of insanity and its relation to crime, and likewise what I consider should be the true aim of punishment. Punishment is always right if it is the best means of counteracting in an individual those morbid tendencies which render him an anti-social being, and is fitted to
make him, as far as possible, conform to the laws which are essential to the existence and progress of the social organism. It follows from this that it must be a mere question of practical utility where, when, and how punishment is to be meted out. Were lunatics persons entirely devoid of self-control and quite unaffected by external agencies, then the question of punishment would be an absurdity; but as an actual fact lunatics are amenable to various degrees to the same influences as affect all members of society. Nothing then can be more absurd than to say that because a man is insane he should on that account be exempt from punishment. For what, it may be asked, is our present system of asylums management but a practical recognition of this fact?

Industrial occupation is, par excellence, the one condition best adapted to guide the patient into healthy channels of thought, and pave the way towards recovery. In asylums it happens now and again that great difficulty is experienced in inducing a patient to work. Coaxing and kindness are alike inefficient in overcoming his perversity; and more is one instance where the infliction of punishment is imperative in the patient's own interest. A dose of hypnotism administered hypodermically
is in most cases a speedy and effectual remedy, and may indirectly initiate the first step towards the patient's recovery. Upon salts with tincture of Jessamine may be advantageously given, the efficacy being all the greater if it is found necessary to use the stomach pump. Other means which may be tried are the administration of an enema, cropping closely the hair of the head and face, depriving the patient of liberties such as tobacco and snuff, clothing him with a ragged suit, or causing him annoyance by fastening a heavy bag of sand to his back and compelling him to carry it about. I have been known one or other of these means to fail after kindness, complicity, and bribery had no effect whatever. I have also found a taste of hypocras or to be of wonderful efficacy in some cases where persistent mischievous behaviour was the outcome rather of wilful malignity than the result purely of disease. These are instances where the infliction of punishment, such as I have alluded to, is indicated, and it is justified as being truly treatment calculated to improve the mental condition of the patient in the manner most conducive to his own welfare and that of the community.

Conclusion

The general conclusions which I have formed regarding the employment of re-
Strain in the management and treatment of the insane, may be briefly summed up as follows:

1. Restraint of some kind will always be necessary while insanity exists as it is at present.

2. It should be limited in its application so far as is compatible with the welfare of the patient and the interests of the public.

3. Restraint should, as far as possible, be graduated to meet the exigencies of each individual case.

4. Direct control, moral and physical, by good attendants under the guidance of the higher asylum officials, is the best means of attaining to this end.

5. Restraint other than that exerted in this way is not frequently required in any well managed asylum where due attention is paid to the requirements of the patients with respect to food, clothing, shelter, industrial occupation, and amusement.

6. Cases occur occasionally where exceptional restraint is imperative, physical force at the hands of attendants being fraught with danger of personal injury.

7. In the majority of such cases seclusion is to be preferred to either mechanical or chemical restraint, as being safer, and a more beneficial and humane procedure, than is re-
8. The use of mechanical apparatus for purposes of restraint can only be justified in surgical cases, to prevent interference with dressings, and in cases of emergency as a temporary expedient, until other and more beneficial means of restraint are available.

9. The systematic use of stupefying drugs as a means of restraining lunatics is a pernicious practice engendering danger to life and permanent injury to health.

10. Their occasional use, together with such remedies as cold baths, nauseating drugs, etc. is sometimes indicated as punishment, and is justified as being the most speedy and effective means of checking morbid tendencies and of inducing the unfortunate patient to the path that leads to mental health—perhaps to ultimate recovery.

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Rosewell, Edinburgh.
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