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The Evolution Of Restraint In American Psychiatry

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THE EVOLUTION OF RESTRAINT IN AMERICAN PSYCHIATRY

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by
Danilo Rojas-Velasquez

2017
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ABSTRACT

History/Social Science:
The Evolution of Restraint in American Psychiatry
Author: Danilo Rojas-Velasquez

In psychiatry, restraint generally refers to direct methods such as mechanical restraints or the use of drugs. Despite psychiatrists’ best efforts to utilize restraint judiciously, many patients still view it as the field’s defining feature, especially on inpatient units with involuntary commitment, medications against will, and locked doors. This essay is an attempt to understand the pervasiveness of restraint in psychiatry. It uses changes in the practices of restraint to examine the growth of the field over time. To accomplish this, the paper identifies three distinct regimes of restraint: the moral treatment of the 1800s, associated with the asylum; the somatic treatment of the early 1900s, associated with psychosurgery; and the pharmaceutical treatment of the later 1900s, associated with pills. The essay analyzes primary sources drawn from the scientific and psychiatric literature of each period, in addition to marketing materials. It also examines the work of prominent figures associated with each regime, including Samuel Tuke, Clifford Beers, and Walter Freeman. The paper engages the work of a range of historians of psychiatry, including David Rothman, Michel Foucault, Andrew Scull, and David Herzberg. Two major conclusions are drawn. First, restraint evolved from the physical form seen in madhouses to self-restraint first seen in the early asylum. The role of the psychiatrist followed this evolution, as the psychiatrist increasingly became the figure to help patients achieve self-restraint. Secondly, because psychiatrists became the judges of how much self-restraint is acceptable, they have come into conflict with society during periods of change, which contributes to the stigma and backlash against psychiatric practice.
ACKNOWLEDGMENTS

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I would also like to thank the Section of the History of Medicine for the support provided. Melissa Graffe in particular was helpful in showing me what resources were available for my research and how to access the various libraries at Yale to find primary and secondary sources.

Finally I am grateful to the Office of Student Research for allowing me to pursue my interests in the history of medicine and be involved in historical research as a medical student. Being able to revisit the study of history while in medical school allowed me to develop a broader perspective and see medicine in a historical context. This was a very enlightening and valuable experience for me as a future physician and will help inform the way I think about patients and the practice of medicine.
INTRODUCTION

Restraint in modern medicine refers to specific methods of handling violent or disruptive patients to ensure safety for all parties involved. Patient violence can occur in many settings, with emergency departments and psychiatric wards being amongst the most common. It is no surprise to see security and police, cameras and alarms, and locked entrances in these settings, signs of an overt, physical form of restraint that can be called upon when necessary. Restraint is medically defined as the “forcible confinement or control of a subject” used only when the “behavior poses a danger to himself or herself or another person”. Restraint can be achieved through physical and chemical means, and requires a medical indication, such as confusion, disorientation, psychosis, or agitation. Restraint is viewed as a temporary measure used until the patient’s condition, whether it be due to drugs, alcohol, or metabolic derangements is solved. In the world of medicine, restraint is seen as a tool to protect the patient and to safely treat the underlying condition.

Restraint is particularly pervasive in psychiatry, primarily because psychiatrists have to handle the medical conditions like psychosis, delirium, and substance abuse that predispose patients to dangerous behavior. Psychiatrists wield a great deal of power, having the ability to hospitalize patients against their will and to medicate patients without their consent, as long as the legal system supports their decisions. Psychiatric inpatient units are one of the few places in the hospital that remain locked. On locked units, patients are constantly observed and watched, and the most acute patients often

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have around the clock supervision if their condition merits it. Physical restraints are still present in psychiatry, although seldom used in most hospitals. Patients who display aggressive or violent behavior are often put down by security and forced to take medications to calm down.

Although medical professionals may view restraint as an unfortunate but necessary tool, patients often have a different perspective. For many patients, the idea of psychiatric treatment is often deeply connected to the idea of control. Straightjackets, sedatives, and padded cells are images that continue to represent psychiatric treatment for patients despite the fact that they are no longer used. Admission to a psychiatric ward is often described by patients as being “locked up”. The ideas of involuntary commitment, mandatory medication adherence, and rules regulating behavior are often met with resistance and fear by patients because they are restraints on their liberties.

While restraint is still physically present in psychiatry, this paper will focus more on how restraint has evolved to move away from the overt physical form to a restraint of self that serves to keep unacceptable behaviors and impulses at bay. Restraint will be defined as essentially control of behavior, and will deal with the question of who does the controlling and through what means. The concept of self-restraint is defined as control of behavior by the patient. Of course, the method to attaining the ability and desire to control their own behavior will depend on how the psychiatrist treats the patient, which will be a main question that will be explored.

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Throughout history, restraint and psychiatry have had a close relationship. This is especially relevant to American psychiatry, where the field has strived to be considered a scientifically and medically valid discipline within the medical establishment. Today, psychiatric treatment has a strong foundation within neuroscience, biochemistry, and drug development to be objective as possible with identifying and treating mental disease, and is considered an established discipline within medicine. However, this has not always been the case, as psychiatry has struggled to find an identity, and it is this search for an identity that will be explored through the lens of restraint. As psychiatry transforms through madhouses to asylums to shock therapies and lobotomies to drugs and neuroscience, the end goal remains the same, which is the restraint of behavior. What changes is how this is achieved. Essentially, the methods of achieving restraint shift from the physical outward restraint of the madhouse to helping the patient restrain their own behaviors and impulses through moral treatment, somatic treatment, and ultimately drugs.

Using the concept of restraint to explore the historical shifts within psychiatric treatment is important and applicable to understanding two main tensions within psychiatry, which helps inform us of which direction the field may head in as we look towards the future.

The first tension is the push and pull relationship between provider and patient revolving around behavior and restraint. The way we study psychiatric disease is unique in that we look at behavior, and identify which behaviors are healthy and which ones need to be controlled. This puts the psychiatrist in a powerful position, but can cause problems with patients who do not want to change their behavior. Therefore, treatment can become an issue of control, and we will see that when psychiatrists exert too much
control, such as removing personality with lobotomy or suppressing unruly citizens in asylums, patients, and society as a whole, push back. Exposing this tension is applicable to today because it informs psychiatrists of the complex provider-patient relationship and puts the relationship within the context of American history.

The second tension resides within the field, namely the desire to be considered a medical and scientific field in the face of historically shaky diagnostic categories and treatment efficacy. Throughout history, it has been difficult for physicians to describe mental illness because unlike other medical conditions, many mental illnesses do not have clear cut pathology or lesions to point to. This makes treatment difficult, and as will be described, forces doctors to place a premium on efficacy rather than understanding why the treatment works. This tension is important to understand because while it can make psychiatry difficult, it also opens up room for growth and innovation. The field faces new challenges in the American landscape, and needs to continue questioning its methods because of the close relationship between psychiatry and society.

The paper focuses primarily on the history of American psychiatry and covers an extensive time period starting roughly from the inception of psychiatry in the US all the way to the present. It is necessary to start at the infancy of American psychiatry in order to understand how the motivations behind the field, especially as it revolved around treatment and restraint. These motivations will help guide the following discussions over how and why psychiatry shifted away from its 19th century manifestation. One of the earliest American works revolving around the history of psychiatry was The Mentally Ill in America by Albert Deutsh in 1937. Deutsh provided a thorough history of the

evolution of psychiatry and how people have thought about the mentally ill. A few years later in 1941, Gregory Zilboorg published *A History of Medical Psychology*, a work that looked at the history of psychiatry from a psychoanalytic perspective.\(^4\) In the 1940s, following WWII, the history of American psychiatry gained increasing attention, and the American Psychiatric Association began to put more of an emphasis on the study of history, starting with the creation of the Committee of History in 1941. Authors began to write about psychiatry using a more social and cultural perspective. David Rothman in *The Discovery of the Asylum; Social Order and Disorder in the New Republic* and Gerald Grobb in *Mental Institutions in America: Social Policy to 1875* both discuss the asylum within the context of American society and culture.\(^5\)

Various sources will be used to explore this evolution, focusing on the dichotomy in perspective between patient and provider to discover what the end goal of treatment was and relate it to the idea of restraint. The asylum period from the early 1800s to the turn of the twentieth century draws upon asylum superintendent annual reports, correspondence between superintendents, and remarks from regional and national conferences. The psychiatric literature published at the time, particularly from *The American Journal of Psychiatry* will also be studied with a focus on the use of restraint and the methods of asylum care. Most of the largest asylums at this time were located in the Northeast United States, and so most of the records examined are from this region. The secondary literature around institutionalized psychiatry draws upon authors like Michel Foucault, Andrew Scull, and David Rothman. To obtain the patient perspective,

special attention is paid to Clifford Beers and his book, *A Mind That Found Itself*.\(^6\) Beers provides a unique account of asylum life and inspired his later work with the mental hygiene movement.

The turn of the century saw advances in medicine that would influence psychiatric practice to move away from the custodial nature of the asylum to what was termed somatic treatment. This era saw the rise of treatments like insulin shock therapy, ECT, and eventually, psychosurgery. For this period, sources from the psychiatric literature are studied to get a sense of the theory behind somatic treatment, the psychiatrist perspective, and what they were trying to achieve. Psychosurgery in particular is given an increased focus because it represents one of the most drastic and controversial forms of treatment in medicine. The patient perspective regarding lobotomy is drawn from patient and family correspondence with Walter Freeman, one of the most popular proponents of lobotomy. Mical Raz, in her book, *The Lobotomy Letters*, provides a relevant discussion to how lobotomy was contextualized within psychiatric thought.\(^7\) She offers an insightful perspective on the part of the providers and how they viewed lobotomy as a treatment tool.

The 1950s were another transition period within psychiatry that witnessed the decline of somatic treatment and the rise of pharmaceuticals. One major source that will be examined for this period is drug advertisements. Authors like Jonathan Metzl and David Herzberg have examined the role that drug advertisements played in how the public viewed psychiatric drugs, with a focus on gender roles and how drugs were

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targeted towards women. These arguments will be drawn upon to show how pharmaceuticals and the idea of self-restraint went hand in hand.

The paper will be structured into three main chapters, each focusing on a distinct era of American psychiatry. The three eras have been identified primarily on the prevalent treatment modality used at the time. The rise of the asylum and moral treatment in the 1800s will be examined to understand how moral treatment laid the groundwork for the idea of self-restraint in patients. The chapter will then discuss how the asylum eventually declined into a more custodial system, where patients were kept with little hope of re-entering society again. Clifford Beers’ account of his treatment at an asylum will be used as a starting point for the patient perspective regarding asylum and restraint.

This will lead to the second chapter, which will focus on the first half of the twentieth century when somatic treatment and psychosurgery became widespread treatment options. This chapter will explain why psychiatrists gravitated towards these treatment tools and what their goal was within the context of the idea of restraint. The argument will be made that these treatments were a way to more directly achieve the ideal of self-restraint in the patient, making them able to re-enter society. The patient perspective during this era will be drawn primarily from patient and family correspondence regarding lobotomy.

The third chapter will look at the rise of psychiatric drugs in the 1950s and how pharmacy gave psychiatrists a new tool to achieve restraint. Drug advertisements will be studied to see how they fall in line with the narrative of restraint amidst a broader social and political context in which drugs were major players as solutions to societal problems.

In addition, we will see how psychiatry as a field was changing as de-institutionalization changed the landscape that psychiatrists practiced in. The psychiatrist perspective will also be examined, focusing on how the rise of biological psychiatry changed how psychiatrists thought about restraint. This will transition to the conclusion, which will explore how psychiatry’s past continues to inform its relationship with society and how the field will need to continue to adapt to meet the changes within American society.
Chapter 1: From Madhouse to Asylum

This chapter will discuss the asylum period of the 19th century and explore the rise and fall of moral treatment. To do this, the chapter will first focus on the treatment of the mentally ill in Western Europe in the 1700s. Understanding how the institution of the madhouse came to be considered a viable option for the mentally ill is crucial to understanding the goals behind moral treatment as well as understanding the origin of the motifs of physical restraint. The painting above by William Hogarth illustrates the themes...
that have been associated with madhouses.\textsuperscript{9} These themes include patients left to their own devices and misery, chains and shackles, and a loss of civilized order. Even in their time, madhouses did not invoke a positive image of madness.

The chapter will then explore the events that led up to the rise of the asylum in the United States. This will include a discussion of treatment of the mentally ill before the asylum and the reform movements that spawned out of the inadequacy of this treatment, which will be followed by an exploration into moral treatment. By elucidating the goals behind moral treatment in the asylum, we will examine how it fits into the framework of restraint, making the argument that although psychiatrists were trying to get away from the physical manifestation of restraint of the \textit{ancien regime madhouse}, they were in effect trying to achieve a new form of restraint that was more inward, a self-restraint. This is an important point because it signals the birth of self-restraint with the psychiatrist playing the central role of judging what constitutes socially acceptable behavior. This role of psychiatrist as a judge of self-restraint will be a central theme for the rest of the paper because it informs how we will view psychiatric treatment. The chapter will then delve into the failings of the asylum and its deterioration into a method of confinement rather than treatment. It will conclude with an in-depth look into the patient perspective of the asylum, particularly that of Clifford Beers, a well-known advocate of mental hygiene who wrote a detailed account of his own treatment in an asylum.

\textit{The Ancien Regime Madhouse}

\textsuperscript{9} \textit{A Rake’s Progress} is the final painting in a series by Hogarth depicting the fall of Tom Rakewell, the son of a wealthy merchant who travels to London only to engage in prostitution and gambling. He is eventually imprisoned for failure to pay debts and then spends his final days in Bedlam.
To understand the American asylum of the 1800s, it is important to examine its predecessor, namely the European madhouses of the 17th and 18th centuries. It is from this period that the popular image of the asylum with its barren cells, chains and shackles, and straightjackets comes out of. In *Madness in Civilization*, Scull makes the point that the madhouse arose not as a novel way of treating madness, but rather was born out of a growing consumer culture in Western Europe.\textsuperscript{10} Many madhouses were for-profit institutions, run by a variety of different professions, including clergymen, businessmen, and physicians. The goal was not necessarily to treat, but to confine. To this end, patients were often mixed together regardless of what they might be suffering from, and the most troublesome patients were kept in cells chained to the walls.

One of the reasons the madhouse arose as a viable option in dealing with the mentally ill was the belief that people who had gone mad had lost all reason and were incurable. Therefore, there was no choice but to confine these people away from society with physical restraint being the only way to “treat” patients. The term “treatment” in the madhouse period is used loosely, because confinement was not viewed not so much as a curative tool but rather a tool to keep the patient safe and under control. The most violent patients were typically kept chained to the walls and beds whereas calmer patients were placed into wards with a bit more physical freedom. One example of this is a description of a patient with seizures who was “placed in a pigsty, feet and fists bound; when the crisis had passes she was tied to her bed, covered only by a blanket; when she was allowed to take a few steps, an iron bar was placed between her legs, attached by rings to

her ankles and by a short chain to handcuffs.”¹¹ This patient with uncontrollable seizures was heavily restrained not with the intention of treating the seizure, but more so to provide some degree of safety and control.

In 18th century Europe, the prevailing belief regarding reason was that it was what made man human, the quality that separated man from beast. To lose reason and go mad was to become inhuman and beast-like, and there was no hope of ever coming out of madness. Blaise Pascal, a prominent French philosopher, summed it up by writing, “I can easily conceive of a man without hands, feet, head ... But I cannot conceive of a man without thought; that would be a stone or a brute.”¹² Because of this, madness was viewed as an inhuman quality, and the mad were to be restrained and confined. This contributed to the zoo-like descriptions of madhouses. One description of La Salpetriere reads, “Madwomen seized with fits of violence are chained like dogs at their cell doors, and separated from keepers and visitors alike by a long corridor protected by an iron grille; through this grille is passed their food and the straw on which they sleep; by means of rakes, part of the filth that surrounds them is cleaned out.”¹³ The language used here is that of the menagerie, with patients having “keepers” rather than doctors or nurses, with straw beds surrounded by filth, and with the physical separation between patients and visitors. The parallel between beast and insanity is important here because it explains why the mentally ill could so easily be locked up in madhouses. Much like beasts need to be physically restrained for the safety of society, the insane must also be restrained, both for the safety of others and their own safety.

¹³ Foucault, pg 68.
Physicians were actually in agreement with this, and advocated for harsh, authoritative treatment of madness. Thomas Willis, one of the pioneers of neurology, wrote, “To correct or allay the furies and exorbitancies of the Animal Spirits…requires threatenings, bonds, or strokes as well as Physick. Furious Mad-men are sooner and more certainly cured by punishments and hard usage, in a strait-room, than by Physick, or Medicines.”14 Patients were to be kept locked up in cells and control was achieved through physical means, with the use of chains and straightjackets. Francis Willis, an English madhouse owner who treated King George III, made this clear when he wrote, “The emotion of fear is the first and often the only one by which they can be governed. By working on it one removes their thoughts from the phantasms occupying them and brings them back to reality, even if this entails pain and suffering.”15

*Technologies of Physical Restraint*

The idea that the mentally ill had to be controlled and subjugated led to a period in the late 18th and early 19th century that saw a rise in new technology designed to physically restrain the patient. These new tools were introduced largely by physicians, who had now come to claim the domain of madness as a medical endeavor. It is within this period that the “treatment” of insanity receives more attention, with physicians beginning to think about how best to treat the mentally ill and attempt to provide some degree of a cure. While some doctors continued to view physical restraint as a form of

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15 Francis Willis, cited in Scull, pg 155. Originally cited in Ida Macalpine and Richard Hunter, *George III and the Mad Business*. Macalpine and Hunter were mother and son and both psychiatrists who argued that George III suffered from porphyria. Their work provided an in-depth view of 18th century thinking of medicine and mental disease.
treatment, others, like William Tuke, Philipe Pinel, and Jean Esquirol began to formulate the idea of moral treatment.

Benjamin Rush, one of the pioneers of American medicine and psychiatry, falls into this period of medicine and combines elements of both madhouse and asylum treatment. Although he was a proponent of occupational therapy for the mentally ill and worked to introduce mental wards in hospitals, he also believed that bloodletting and purging were valid treatments. Rush is particularly known for “The Tranquilizer,” illustrated in Figure 1.

As can be seen in the figure, the tranquilizer achieves complete physical restraint, with the patient’s ankles, wrists, and body fastened to the chair and the patient’s head locked into place so that hearing and vision are eliminated. The name of the tool itself speaks to the explicit goal of physical restraint as it tranquilizes any impulse the patient may have. Rush wrote, “It binds and confines every part of the body. By keeping the
trunk erect, it lessens the impulse of blood toward the brain.”\(^\text{16}\) It is clear that Rush was not attempting to engage the patient or teach the person how to control or understand their behavior. Rather, he seeks to physically keep the madness away by tying the patient up, thereby preventing the behavior through force.

However, this type of physical restraint still represents a shift from the chains and shackles of the madhouse and also foreshadows the somatic treatments introduced a century later. Rush created this device with the goal of having some degree of physiological effect, namely cutting off circulation to the brain, with the belief that this intervention would target the insanity. This is in contrast to the zoo-like conditions of the madhouse, where patients were restrained for lack of any alternatives. This speaks to the growing role of medicine in insanity, as physicians like Rush begin to try to explain and treat madness as a medical problem. As treatment develops however, the idea of restraint continues to persist.

In Europe, other techniques of physical restraint began to arise as well. Joseph Mason Cox, an English madhouse owner, developed a swinging chair, a device that had the patient strapped to a chair as they were swung like a pendulum.\(^\text{17}\)

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Figure 2: Joseph Mason Cox, taken from Joseph Guislain, Traité sur l'aliénation mentale et sur les hospices des aliénés, Amsterdam, 1828.

Figure 2 illustrates the overt physical restraint of the chair, with the patient once again bound at the ankles, wrist, and body. The patient is shown at the mercy of the attendant, as the patient is powerless to comment on what he feels as he is swung around. The physical restraint alone is viewed as “treatment,” with subjugation of the patient being the goal.

Backlash against the Madhouse

Given the nature of the madhouse, with its imprisoned patients, its chains and shackles, and its isolation from society, it should be no surprise that the madhouse came to be painted in a negative light, even as early as the 18th century. One former patient, William Belcher, had been in a madhouse for seventeen years, and spoke about the horrors of his experiences, being “bound and tortured in a strait-waistcoat, fettered,
crammed with physick with a bullock’s horn, and knocked down, and declared a lunatic by a Jury that never saw me…” The language of physical restraint is clear here, with the straightjacket and forced medication, and Belcher states clearly that all this happened to him despite not having been formerly diagnosed or charged with a crime. Physician William Pargeter echoed these sentiments, writing, “The idea of a mad-house is apt to excite, in the breasts of most people, the strongest emotions of horror and alarm; upon a supposition, not altogether ill-founded, that when once a patient is doomed to take up abode in these places, he will be exposed to very great cruelty.”

Governments and physicians began to pay closer attention to how madhouses were operated, especially given the increased state funding of institutions in Europe and the USA. English reports made to the House of Commons reveal the theme of physical restraint present in the madhouse. One witness described Bedlam patients, “Their nakedness and their mode of confinement gave … the complete appearance of a dog kennel.” This describes a very physical type of restraint, with conditions being so crowded that patients could not move, similar to the confinement of animals. Patients were hardly kept healthy, often being stuffed into small rooms and suffering from gangrene and tuberculosis.

Another report describes a room, “twelve feet by seven feet ten inches, in which there were thirteen women … I became very sick and could not remain any longer in the

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18 William Belcher, Belcher’s Address to Humanity, 1796. Taken from Allan Ingram, Patterns of Madness in the Eighteenth Century: A Reader (Liverpool University Press, 1998) pg 187. In his pamphlet, Belcher speaks out against his wrongful confinement, arguing that treatment in the madhouse is designed to create insane people and used by “hyenas” to prey upon the wealthy.
19 William Pargeter, Observations on Maniacal Disorders, 1792, Printed for the author, pg 123.
20 House of Commons, Report of the Select Committee on Madhouses, 1815, pg 3. The early 1800s witnessed an increase in the number of complaints to the House of Commons against madhouses as independent philanthropists and magistrates toured the country inspecting madhouses. Much of the English perspective on the madhouse comes from these reports to the House of Commons.
room. I vomited.” The room in this description evokes the image of a tight, restraining space literally packed with thirteen patients. With rooms this small, it is easy to imagine just how difficult it was for patients to even move freely, revealing just how physically restraining the madhouse itself could be. Patients being kept and treated like beasts, crowded filthy interiors, and the chains and the straitjacket were all common themes in reports, revealing how prevalent the presence of physical restraint was in the madhouse.

**The Rise of Moral Treatment**

The horrors of the European madhouse along with the inadequacy of treatment in the USA led to the rise of reformers like Dorothea Dix, who began to pressure state governments to start sponsoring institutionalized treatment of the mentally ill. This new institution, the asylum, arose amidst a great deal of change within the field of mental illness, particularly in European medicine. Therefore, it is important to first examine the European perspective of moral treatment in order to understand how it was implemented in the US. In the late 1700s, physicians such as William Battie and Phillipe Pinel began to advocate for the medical treatment of mental illness centered not on physical restraint but rather a more individualized, specialized treatment. Battie was one of the first, writing *A Treatise of Madness* in 1758, and arguing that mental illness came from the brain and body rather than the mind.22

In England, William Tuke established the York Retreat in 1796, a small institution in the countryside where patients lived in a communal setting. According to

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21 *Ibid*, pg4-5. This was an account of the York Asylum by magistrate Godfrey Higgins.
22 William Battie, *A Treatise on Madness*, 1758, London: Printed for J. Whiston and B. White. Battie was an English physician and argued that insanity should be managed differently than the purges and blood-letting practiced at Bethlem. He was one of the first to differentiate mental illness into “original” and “consequential” and advocated for treatment through engaging the patient.
Tuke, most insane patients have some degree of self-control, which should be cultivated and strengthened to achieve satisfactory conduct. Here we see the early beginnings of “self-restraint.” Patients were recognized to still retain some capacity to restrain their own self, and moral treatment was one way to cultivate this capacity. In a sharp departure from earlier madhouse keepers, instilling fear in patients would only make their mental illness worse, and so the use of physical restraints and punishments should be avoided. A patient’s care was driven by the patient’s conduct, as patients who demonstrated higher levels of self-restraint were viewed as being less symptomatic and as improving their illness.

With both Tuke and Pinel, one can see the evolution of restraint from physical to self. Rather than chain patients down and keep them in small cells, patients were given increasing amounts of freedom so long as they could exercise and demonstrate self-restraint. Tuke illustrates this when he writes about one patient with mania who, when he first arrived, was menacing and violent, often threatening the attendants. The superintendent avoided restraining him however, electing instead to talk to the patient and demonstrate kindness. The patient was “sensible to the kindness of his treatment. He promised to restrain himself, and he so completely succeeded that, during his stay, no coercive means were ever employed towards him.”24 The idea that insanity arose from the body and brain and not from bestial tendencies or an inherent lack of reason gradually

23 Samuel Tuke, Description of The Retreat, an Institution near York for Insane Persons, Philadelphia, 1813, pg 90. The York Retreat was founded with the intent on minimizing restraint and replacing it with labor and talk, and served as an influential model for later American asylums. Tuke was actually not trained as a physician but was instead a businessman and philanthropist. He was heavily influenced by his Quaker background, which informed many of his beliefs about the treatment of the mentally ill.

24 Ibid, 93.
led to insanity being a medical problem, allowing it to be viewed in terms of symptoms rather than a degradation of man to beast.

The American reformers in particular used the moral treatment model advocate for state funding of new asylums, often using exaggerated claims related to efficacy. Reported cure rates were claimed to be upwards of 70%, and Dix exemplified this when she wrote, “All experience showed that insanity reasonably treated is as curable as a cold or a fever.” Asylums began to grow in number as more and more states began to sponsor them. These asylums needed physicians to run them, leading to the growth of the profession of the asylum superintendent, the precursor to the eventual “psychiatrist.” American asylum superintendents were heavily in favor of moral treatment and non-restraint, as evidenced in their asylum reports to state legislatures and correspondences between superintendents.

In an 1854 report from a Massachusetts asylum at Worcester, superintendents claimed that since the opening of the asylum, 4757 patients had been admitted, and 2172, almost half, had recovered and been discharged. The superintendents attribute this success to moral treatment, stating that “neither seclusion nor restraint of insane persons is necessary, saving in rare and exceptional cases.” Echoing Tuke’s work, they go on to say that,

Insanity, as was remarked before, deranges, but does not alter, the nature of man…opposition provokes to anger, and that the soft answer turns away the wrath of insane as well as of sane men. We are to consider the principle, that whatever directly represses the individuality, whatever restrains the personal liberty, instantly excite opposition, temper, and rebellion.

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Here one can see the sharp departure from the 18th century idea of insanity. Madmen have not lost their reason and are still human, and so physical restraint only serves to exasperate the insanity rather than alleviate it. In place of chains and straightjackets, superintendents used physical labor, activities, and talk with the goal of improving patient conduct, or the patient’s self-restraint.

A report from the Connecticut Hospital of the Insane written in 1879 sums this up by stating that, “one of the most efficient elements in the treatment and restoration of insane persons may be found in the regularity of hospital life, and the moral restraint therein exercised.” Superintendents compared patients to children, stating that they have unbalanced, uncontrolled thoughts, and by using goal directed work, such as labor in the fields, patients can be redirected and taught to exercise self-restraint. This philosophy was not limited to superintendents. State governments were in agreement, with several states, including New York, which had some of the largest and oldest asylums, passing legislation to limit or abolish mechanical restraints. The New York law actually stated that mechanical restraint would instead be replaced by “useful occupations, diversions, and amusements of various kinds,” thus explicitly stating restraint was no longer about physical chains and shackles, but rather a restraint of self, achieved through goal directed activities.

*The Asylum*

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Whereas the image of physical restraint could be seen in tools such as the “tranquilizer”, the swinging chair, and the straitjacket, the image of self-restraint can be represented by the asylum itself.

Figure 3: The York Retreat, 1796. Image taken from Andrew Scull, Madness in Civilization, Princeton University Press, 2015, pg 203.

Figure 3 shows the York Retreat. The building itself is small, and is surrounded by the countryside, highlighting the importance of seclusion from the city. The building stands in the background, giving space to show the vast surrounding free space. This serves as a stark contrast to depictions of the madhouse with its small, crowded cells. The image also shows a man walking back with a mule, signifying the rural landscape. The vegetation adds a calming element to the image, again highlighting the therapeutic and free ambience around the building. Naming the asylum a “retreat” further adds to the building as a place of escape and healing. All these elements come together to show the asylum as a free, open space where patients could be admitted to work through their
mental illness. Here, patients could learn how to restrain their own impulses and behaviors through farm work and other activities.

![Garden of the Hospital in Arles, 1889](https://via.placeholder.com/150)

Figure 4: Garden of the Hospital in Arles, 1889. Taken from Jan Hulsker (1980), *The Complete Van Gogh*, Oxford: Phaidon, pg 1687.

Figure 4 is a painting by Van Gogh of the garden at Arles, and one can see the greenery, spaciousness, and freedom of the garden, which is again in sharp contrast to the cramped madhouse halls of the 18th century. The garden represents freedom, so long as the patient can demonstrate enough self-restraint to partake of it. No images of physical restraint are present here, with people on the second level freely walking over the garden. Patients were still not free in the asylum, with their behavior and interactions with others under close scrutiny by attendants and superintendents. The goal now was not to keep patients physically under control, but to improve their ability to control their impulses and restrain themselves to maintain satisfactory conduct.

**Deterioration of the Asylum**
By the late 19\textsuperscript{th} century, psychiatry had cemented itself as a distinct medical profession. It had shifted from the harsh physical restraint of the madhouse to the self-restraint of the asylum, grounded in moral treatment. This evolution, however, failed to be much more effective than the madhouse was in effecting a cure from insanity. The number of institutionalized patients continued to rise, but cure and discharge rates plummeted. This deterioration led to a backlash against psychiatry, the asylum, and the moral treatment model. Asylums began to look very different from the early York Retreat as they became increasingly crowded, and transformed into centers of confinement.

The asylum population continued to rise in the late 1800s as confinement became the preferred treatment setting for the mentally ill over the domestic setting. More and more patients were admitted while asylums failed to produce cures, leading to chronic patients destined to be confined for years. The sentiment of hope among psychiatrists at the turn of the 19\textsuperscript{th} century had become bleak. W. A. F Browne, a staunch supporter of the asylum and moral treatment, wrote in 1852 about insanity, “how intractable the disease is found to be and how indelible its ravages are even where reason appears to be restored”\textsuperscript{30}. He goes on to describe patients as “the manic glorying in obscenity and filth; devouring garbage or ordure, surpassing those brutalities which may to the savage be a heritage and a superstition”.\textsuperscript{31} Descriptions such as these began to sound less like the healing gardens of Tuke and more like the ancient regime madhouses. The asylum had transformed into a monotonous, violent, overcrowded institution for all parties involved, including superintendents, attendants, and patients.

\textsuperscript{30} Crichton Royal Asylum, 9\textsuperscript{th} Annual Report, pg 5.
\textsuperscript{31} Crichton Royal Asylum, 13\textsuperscript{th} Annual Report, pg 40.
The Patient Perspective

Patients sometimes had different views of the asylum than the superintendents. While most asylums kept extensive records and statistics regarding treatment, patient accounts are rarer, owing in part to literacy, cost, and the stigma associated with being a patient in an insane asylum. Patients who did write about their experience were often much more educated and had the means to publish. Therefore, it is difficult to fully understand the patient perspective because most records are written through the lens of the psychiatrists. In addition, most people who did write about their perspective were more likely to be motivated to speak out against the asylum, providing a more biased view of the experience.

One of the earliest and more public patient accounts of the asylum is by Ebenezer Haskell, who had been hospitalized in the Pennsylvania Hospital for the Insane in 1868 and later sued the institution after escaping the hospital. Haskell believed he was wrongly institutionalized, and so provides a very critical view of the asylum, with a particular focus on the methods used by attendants to treat patients. He describes one patient he saw lying upon his bench a wretched creature, heavily ironed, and covered and surrounded by filth indescribable … The keeper said that occasionally when he was in a quiet state this man was guarded in a short walk about the yard (always chained however) but that for the most part he lay just where we saw him.\textsuperscript{32}

In this description, we can see the images of physical restraint in the iron chains and the fact that the patient is confined to a small space. Haskell describes another incident where he witnessed,

\textsuperscript{32} Ebenezer Haskell. (1869). The trial of Ebenezer Haskell, in lunacy, and his acquittal before Judge Brewster, in November, 1868: Together with a brief sketch of the mode of treatment of lunatics in different asylums in this country and in England, with illustrations, including a copy of Hogarth's celebrated painting of a scene in old Bedlam, in London, 1635. Philadelphia: E. Haskell. 48
a struggle on the floor with a poor victim and his keeper for over half an hour; the poor fellow had his hands strapped close to his body and fought with desperation; he was finally conquered by choking until he was black in the face, his tongue protruding from his mouth ... he was taken off from the floor by two stout keepers and put in a dungeon naked.\textsuperscript{33}

This description is a vivid portrayal of the brutality that patients suffered, and Haskell identifies the person as a victim rather than a patient, which speaks to the mistreatment that patients received while in the asylum. He also describes attendants and nurses as “monsters in human shape”, again painting the asylum as a dangerous environment where people were victimized rather than the therapeutic hospital described by superintendents in their reports.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure5.png}
\caption{Taken from Ebenezer Haskell. (1869). The trial of Ebenezer Haskell, pg 20.}
\end{figure}

In Figure 5, we can see a clear representation of physical restraint with a patient locked to his bed and another patient reaching his hand out a small window. The images are very similar to the early 18\textsuperscript{th} century description of the madhouse, despite originating

\textsuperscript{33} Ibid, 42.
from 1869. The chain tying the patient to his bed, the small cramped room, and the small window all serve as overt physical restraint. The attendant holding the keys to the room serves as a reminder that these rooms are also kept locked, resembling more of a prison cell than a patient bed. The image shows two attendants appearing as imposing figures as the patient looks at them with fear and apprehension, again highlighting the physical aspect of restraint as the two attendants clearly have the power in this situation.

Figure 6: Taken from Ebenezer Haskell. (1869). The trial of Ebenezer Haskell, pg 20.

Figure 6 provides another interesting look into physical restraint, with attendants forcibly holding a patient down while the doctor force feeds him. Again, physical restraint takes center stage in this image. The patient is tied down to the chair with his limbs being held. The patient has the least amount of power in this situation, being fed against his will in a very forced manner. The patient is so inept at controlling his own behaviors that even the simple act of eating has to be forced upon him in a very physical way.
Haskell’s images and accounts reveal that while superintendents might espouse the rhetoric of moral treatment at conferences and in professional journals, the actual practice was much harder to put into place. Moral treatment, by its nature, requires close supervision and evaluation of patients to see how they progress and respond. This might have been easy to do in small institutions with few patients and lots of staff, but in many of the large American asylums, the ideal of moral treatment could not be met. This is especially seen in Clifford Beers’ account, which is the topic of the next section.

**Clifford Beers**

Forty years after Haskell wrote his account of asylum treatment, Clifford Beers published *A Mind That Found Itself*, an autobiographical account of his institutionalization in three different asylums from 1900 to 1903. Unlike Haskell, who was involuntary committed against his will, Beers was voluntarily admitted after a suicide attempt. Beers was also more educated, having graduated from Yale University and having experience as a writer before being institutionalized. Due to his status and education, Beers was not the typical patient, and was allowed to write while being treated and even go outside to meet with friends and send letters. Unlike the majority of patients, Beers was very interested in exploring asylum conditions and ideas for reform, and so paid special attention to how he and his fellow patients were treated. His interest in mental health and asylum reform culminated in his mental hygiene movement, and the founding of multiple institutions with the aim of improving mental health in the outpatient setting.

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Like Haskell, Beers focuses his account on the mistreatment of patients with an emphasis on the type of physical restraints used against patients. Beers describes one incident involving the use of hand muffs, a madhouse era technology originally introduced a century earlier. Beers writes,

I was subjected to a detestable form of restraint that amounted to torture. To guard me at night while the remaining attendant slept, my hands were imprisoned in what is known as a ‘muff.’ A muff, innocent enough to the eyes of those who have never worn one, is in reality a relic of the Inquisition. It is an instrument of restraint which has been in use for centuries … I resisted weakly, and, after the muff was adjusted and locked, for the first time since my mental collapse, I wept.35

This description reveals how despite the moral treatment principles that asylums had been built upon, physical restraint was still in use. In this example, Beers is restrained due to his recent suicide attempt in an effort to prevent self-harm, but Beers as the patient views it in a very different manner, which speaks to the difference in perception between superintendent and patient.

Beers describes another incident which occurred after he started a fight with an attendant over a disagreement around slow eating. Beers writes,

After that supper-fight I was left alone in my room for about an hour. Then the assistant physician, the two attendants, and a third attendant entered. One of the attendants carried a canvas contrivance known as a camisole … A camisole, or, as I prefer to stigmatize it, a strait-jacket, is really a tight-fitting coat of heavy canvas, reaching from neck to waist, constructed, however, on no ordinary pattern. During the first seven or eight hours, excruciating pains racked not only my arms, but most of my body. For the first and only time in my life I had hysterics.36

The straitjacket, like the hand muff, is another madhouse form of physical restraint, and one that most American psychiatrists had denounced. Here however, we see a very clear

example of how physical restraint was still in use during the asylum period. For patients like Beers, these physical restraints were deeply troubling, and there is a clear disconnect between the physician view of the utility of restraint and the patient view of being forcibly confined.

Although asylum records often emphasized the statistics showing non-restraint and the low number of incidents requiring physical restraint, the accounts of Beers and Haskell reveal that restraint was still used with much of the same technology that had first appeared in the European madhouses. This speaks to the deterioration of the asylum into a confinement center rather than a hospital. As asylums became more crowded and often became dumping grounds for chronic, uncontrollable patients, physicians and attendants had less time and manpower to use the principles of moral treatment.

Beers comments on how little exercise patients received on the wards or how little opportunity there was for patients to engage in activities. He makes the point that although the asylum rules mandated attendants to take patients for walks, attendants usually preferred to remain inside “playing cards, smoking, and telling their kinds of stories.”37 This observation reveals that while physicians may have built and supervised asylums with the intentions of moral treatment, in practice those principles were not fulfilled largely due to the high number of patients and the lack of attendants willing to execute those intentions.

Self-restraint had become too difficult to achieve as attendants resorted more to physical restraint to achieve order in asylums that became increasingly more violent, crowded, and less able to produce cures in insanity. Part of this was due to rising asylum

37 Beers, A Mind That Found Itself, 166
populations with not enough training to produce adequate numbers of attendants and superintendents. This was compounded by the fact that moral treatment had not produced the optimistic cure rates of the early asylum founders. This failure to produce results is an important point and a common thread in the three periods of American psychiatry, leading to an underlying tension within the field. Psychiatrists have often struggled to define mental illness because most diseases have no clear cut, physical pathology. Therefore, doctors have had many explanations, from differences in head topography to overactive neurochemistry circuits. Moral treatment had not been based on any evidence based clinical science, so once it started to fail, doctors had little explanation or alternatives. Asylums would continue to struggle with this as more and more patients came to be housed in them while physicians tried to do something, anything, to treat them.

Unlike the majority of patients, Beers was actually discharged and able to return to work in 1904. It was during this period of his life that he began to write his autobiography in an effort to draw greater attention to mental healthcare reform. Beers wrote his book for the public, not the psychiatric profession, and so he wrote with a clear emphasis on patient mistreatment and abuse, and also wrote with the goal of sparking reform in the treatment of the insane.\footnote{Dain, \textit{Advocate for the Insane}, 73.} In addition, Beers wrote the book during a time where he still struggled with his own mental health, showing signs of mania wherein his friends and colleagues remarked about his inability to sleep and fervent writing. Adolf Meyer, one of the most prominent American psychiatrists at the time and supporter of
Beers, remarked that “a good share of the writing was done in a state in which adequate insight could hardly be expected.”

Despite his biases, however, Beers did not intend his book to be an indictment or exposè against the asylum. When newspapers began publishing editorials with titles like “Brutalities To Insane Told by Yale Man Who Was A Victim” and “Beaten When He Asked For A Glass Of Water”, Beers wrote letters pleading editors to avoid sensationalist titles because he felt it would take away from his message of reform. A Mind That Found Itself was generally well received, in part because Beers worked closely with superintendents from the Connecticut asylums, and prominent figures in the field like William James and Adolf Meyer. Many superintendents were grateful that Beers had written the book, claiming that it spoke to “the great value of non-restraint, kindness, sympathetic interest in and personal attention to, as well as absolute honesty in the care of and dealings with the insane.” This response on the part of psychiatrists speaks to the efforts to move away from the madhouse and to practice psychiatry in a medically sound way. This desire would help spur a revolution in American psychiatry at the turn of the century.

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39 Adolf Meyer, cited in Dain, Advocate for the Insane, 81.
40 Ibid, 9.
41 Ibid, 98.
Chapter 2: Somatic Treatments and Psychosurgery

By the dawn of the 20th century, medicine was in the midst of a transformation as it became more scientifically based. The work of scientists like Louis Pasteur and Robert Koch made significant contributions to the germ theory disease, paving the way for a new way to practice medicine. This revolution in medicine had had been a long time coming, with its origins in the 19th century. In France, key figures like Rene Laennec, inventor of the modern stethoscope, Marie-Francoise-Xavier-Bichat, pioneer of pathology, and the previously mentioned Philipe Pinel worked to combine medicine and science to think about medical disease in a new way. Bichat in particular was instrumental for his work on the cellular makeup of different tissues in the body and organ based disease.

In the 1850s, Germany took the mantle as the site of medical advancement. Carl von Rokitansky, who served as head of the Vienna School of Medicine, brought pathology to the forefront of clinical medicine. Diseases were now beginning to be studied in terms of the organ that was affected, and pathology became an indispensable tool to corroborate symptoms. This laid the framework for how modern medicine is practiced today, with physicians eliciting symptoms from the patient, studying those symptoms through the physical exam, and then confirming disease with pathology.

Advances in other realms of medicine began to dramatically change the efficacy and scope of practice. Development of antiseptic technique along with the discovery of ether as an anesthetic made surgery much less deadly for patients. Vaccines began to be developed for diseases that had historically ravaged the western world. Vitamins and vitamin deficiencies were discovered. These discoveries were not only groundbreaking, but also allowed for easy treatment for diseases that had long plagued society.
Psychiatry meanwhile, did not benefit nearly as much as other fields with the new breakthroughs in medicine. Despite attempts to implement the laboratory within the asylum, few advances had been made. Progress had been made in understanding and treating syphilis, which was a major cause of psychiatric disease. However, treatment was not perfect, involving arsenic based compounds like Salvarsan that were toxic to many patients. Unlike other areas of medicine, mental illness could not be pinned down to specific lesions in the brain, making characterization of disease difficult. Without a clear understanding of where mental illness came from on the basis of pathology, treatment also became difficult.

Many American psychiatrists began to point to the hereditary and chronic nature of insanity, thus absolving the profession of its ineptness to provide a cure. This was hardly satisfactory however, emphasized by an address by Silas Weir Mitchell in 1894 to the American Medico-Psychological Association. Mitchell heavily criticized the field, stating that asylum superintendents “presided over a collection of living corpses, pathetic patients who have lost even the memory of hope, and sit in rows, too dull to know despair, watched by attendants: silent, gruesome machines which eat and sleep, sleep and eat.”\(^2\) Even as late as the 1930s, Dean of Harvard Medical School David Edsall stated to Rockefeller trustees that psychiatry was dominated by “the speculative the imaginative, the descriptive” and psychiatry needed to integrate the laboratory more effectively like the rest of medicine had done.\(^3\)

\(^3\) David Edsall, “Memorandum Regarding Possible Psychiatric Developments,” Rockefeller Foundation Archives (October 1930).
In addition, asylums had become overrun with patients. Data from the US Census reveals that the number of patients in state asylums had risen from about 130,000 in 1903 to 330,000 in 1933, with a rate of growth near two times that in the general population.\textsuperscript{44} Factors like an increase in the number of admissions and longer hospital stays contributed to this high asylum population. At the same time, asylums were not producing much in the way of cures. Data from New York asylums shows that the rate of recovery per hundred admissions dropped from 22.5 in 1910 to 19.0 in 1940.\textsuperscript{45}

Psychiatrists felt the need and pressure to progress, and so the field underwent a transformation in how it approached treatment to achieve self-restraint in the patient. The argument will be made that although psychiatry was entering a new age with the rise of new technologies like ECT or frontal lobotomy, the goal of treatment continued to be about achieving self-restraint. In addition, these new treatments swung the pendulum to the extreme, being very effective at producing self-restraint, but with severe consequences including the removal of personality altogether. It is also important to keep in mind the role that the psychiatrist plays as arbiter of restraint, and the inherent tension this brings to treatment. While interventions might be described and designed as tools to help the patient control their own behavior, it is still the psychiatrist who decides which patients and which behaviors need the control. Thus, although the restraint of behavior might be internal, there is still the external force pushing patients to control themselves, which creates tension when people perceive that force to be too great.

\textit{The Rise of Modern Psychiatry: Psychiatrist as Judge of Behavior}

\textsuperscript{44} Jack Pressman, \textit{Last Resort: Psychosurgery and the Limits of Medicine}, (New York: Cambridge University Press, 1998), 34.
\textsuperscript{45} New York State Department of Mental Hygiene Annual Report (1950)
American psychiatry as we know it today was actually born in the early 20th century, and although asylum medicine appeared bleak, the rest of psychiatry was undergoing a revolution. This sentiment was captured by psychiatrist Adolf Meyer, who in 1921 proclaimed that “today we feel that modern psychiatry has found itself.”

Meyer is credited with the origin of “psychobiology”, a doctrine that brought together the biological, social, and psychological factors of a patient, thus joining together the study of both the mind and the body. This allowed psychiatrists to look at mental illness from both dimensions, and to consider mental illness as dysfunction in personality rather than purely attributed to pathologies of the brain. Therefore, as experts, they could authoritatively determine what measures would be needed for patients to achieve self-restraint, even if drastic consequences were involved.

Meyer, of course, was very interested in elevating the field of psychiatry within the medical profession, and so his theories of mental illness need to be taken within this context. At this stage, psychiatry did not yet have clear diagnoses based on pathology and physiology. Therefore, by extending the definition of disease to include behavior and adjustment to environment, psychiatrists could better explain disease. The pathology comes not from a lesion in the brain or a chemical imbalance, but from the failure to adapt and adjust to society. Meyer was also making the argument for his particular view

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and approach to mental illness over his predecessors. By expanding the scope of psychiatry, he was extending his own authority and empowering his theories.

Meyer also used the teachings of functionalists like William James and John Dewey to describe mental illness not so much as a biological defect but a lowering of a person’s ability to function in society. Meyer described this as “maladjustment”. With this model, the psychiatrist became responsible for an individual’s ability to be a functioning citizen, thus extending psychiatry’s domain beyond the mental institution to the home, school, and the workplace. Meyer sums this up by writing, “In place of the outdated notions of lunacy we speak today of mental disorders, of psychoses and psychoneuroses, viewed as problems of adaptation of the individual to his environment.” This takes the biological and medical aspect of mental disorder and imbues it with elements of social adaptation, and to a certain extent, control.

Psychiatrists now had domain over behavior in society and the ability to determine if an individual’s failings could be attributed to psychiatric disease. This had major implications for how psychiatrists treated patients with regard to restraint. As explained in chapter 1, restraint in the 19th century had shifted from physical to self, with the goal of treatment being the achievement of behavioral control, with the patient being able to restrain unacceptable impulses. This continued in the 20th century, but was augmented by the new role that psychiatrists obtained within society. As the judges of social adjustment and acceptable behavior, psychiatrists could further define what level

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47 Functionalism refers to a psychological philosophy that defines behavior and mental well-being in terms of how well an individual adapts to their environment. William James is widely considered to be the founder of functionalism. For more, see James Angell, “The Province of Functional Psychology”, Psychological Review (1907): 61-91.

of self-restraint was necessary before someone’s impulses and behaviors could be considered a mental illness. In addition, psychiatrists gained more power in the treatment of insanity, being able to exercise considerable authority over patients. Psychiatrists could now employ more drastic, experimental treatments on patients without much patient consent, in the name of using science and social control.

*Psychoanalysis and the Mind-Body-Brain Connection*

Somatic treatments were focused on the physical body with the goal of providing some form of shock that would somehow induce a change in the brain. Julius Wagner-Jauregg believed that inducing fever on the body could open up the blood-brain barrier and allow Salvarsan to enter the brain. Manfred Sakel believed that using insulin could force brain cells to conserve energy and eventually restore itself. For most psychiatrists working in institutions like the asylum or mental hospital, brain and body were considered connected as part of the physical whole.

By targeting the body and brain, psychiatrists hoped to influence the mind, which ties into the idea of self-restraint. Before moving forward, it is helpful to understand how the mind was viewed within psychiatry during this period, particularly from the psychoanalytic perspective. The foremost pioneer of psychoanalysis was Sigmund Freud, who first began to develop his theories in the 1890s. Freud actually first trained in neurology in Vienna and later studied at the Salpetriere with famed neurologist Jean-Martin Charcot. Freud was heavily influenced by studying neurologic disease, and early on, attempted to explain the unconscious using neuro-physiology.49 Although never

published in his time, Freud attempted to use the current knowledge of neuronal cells and synapses to explain long term potentiation and memory. He theorized that memory in the brain was a “permanent alteration following an event,” which was not far off from the current definition.

Freud later went on to study the unconscious mind, developing theories about the psychosexual phases and the structure of the id, ego, and superego. Although Freud’s theories about the inner workings of the mind were attractive explanations for patients suffering from economic turmoil and post WWI trauma, they were hardly used for American patients stuck in state hospitals.

American psychiatrists were not typically trained in psychoanalysis, and the vast majority of psychoanalysts in this period worked in the outpatient sector. Thus, psychiatrists did not view the mind so much as a single entity but more so something that came out of the brain. To study the mind, psychiatrists looked more at behavior, falling in line more with Meyer’s ideas of social adjustment. A patient who could control their own behavior was of sound mind. To gain that self-restraint, doctors looked to the brain or body as a focus of treatment, using physiological explanations as justification.

Shock Therapies: The New Path to Self-Restraint

In the 1930s, a new type of somatic treatment, insulin shock therapy, was introduced. Insulin shock was first introduced by psychiatrist Manfred Sakel, who experimented with insulin while at a Vienna hospital, where he reported remission rates of schizophrenia as high as 70%. Shock therapies became increasingly used in the US throughout the 1940s. A national survey conducted in 1942 across 305 mental hospitals

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showed that the use of all shock therapies rose from about 10% in 1937 to about 60% in 1941. Examining the scientific literature during this period reveals how psychiatrists viewed shock therapy in terms of restraint. The key, recurring feature of treatment success revolves around a patient’s ability to display self-restraint in their behaviors and thoughts.

For example, a study published in the *American Journal of Psychiatry* describes a patient case with the following.

Ten days after treatment was initiated, he had his first complete coma. That afternoon, he wrote a description of his condition, showing insight. He said he had lost the idea of influencing others, and that while he remembered fully his thought of being Christ, he now realized he was mentally sick. From being restless, picking at his fingers, and smiling inappropriately, he had become friendly, talkative, and cooperative.

In this description, we can see that the psychiatrist viewed the treatment as a success largely because the patient was now able to restrain himself from “inappropriate” behaviors and be “cooperative”. Another description reveals similar sentiments.

Upon admission, he was at first unresponsive and depressed, but the day after was noisy and violent. He became progressively disturbed, ill-natured, combative, destructive of bedding and clothing; would stand nude in his room … During the resulting hypoglycemia, he became responsive to questions and told the physicians he was there because he was ‘nuts.’ Coma occurred and was repeated daily. A week later, he was quiet and cooperative, and mingling freely with the other patients.

Here once again, we see the patient before treatment being described as unruly and disruptive, devoid of any form of self-restraint. After treatment, similar descriptions are used, with the patient being “cooperative and friendly”.

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52 Young, 166.
The evaluation and goals of electroshock therapies were largely the same. In one paper examining electroshock, the author writes,

Clinical evaluation with particular reference to the patient’s higher integrative functions such as spontaneity, sense of humor, originality of thinking and adherence to generally accepted standards of dress and behavior; and the ability to operate on a level consistent with their intelligence, is helpful in giving one a clear understanding of the aspects of shock therapy.\(^{54}\)

Another study from 1945 looking at patient reactions from electroshock reveals much of the same. One case is described with a patient being “agitated, resistive, demanding, and negativistic,” speaking to physicians in a threatening manner and breaking out in meaningless laughter. After receiving 12 shock treatments, the patient eventually became “friendly, cooperative and quiet” and even apologized for threatening physicians.\(^{55}\) Once again, we see that treatment was considered successful when the patient could exercise self-restraint and behave appropriately.

Although doctors were aware of what might constitute treatment success, the understanding of how the treatment worked was less clear. Sakel believed that psychosis was caused by some “noxious agent” that weakened metabolism of nerve cells. By using insulin to cause “hibernation” in the cell, the cell could conserve energy and store it to eventually reinforce itself.\(^{56}\) Ladislas Meduna, one of the pioneers of ECT, offers a similar biological explanation, studying brain tissue in schizophrenia and epilepsy. He noticed that glia cells were nearly absent in schizophrenia whereas there was an increased


\(^{56}\) Sakel, 834.
number in epilepsy. This finding inspired him to experiment with producing seizures in an effort to cure schizophrenia.

Both therapies used cell biology and pathology to provide some explanation for why they might work and produce physiological change, but were limited by the clinical knowledge and technology available at the time. This speaks to the longstanding tension within psychiatry, namely, the need to provide treatment for diseases that are difficult to characterize with clear cut pathology. Even in the present, many drugs are used not so much because it is well understood how they work, but because they’ve been shown to work. Psychiatrists have always lamented the fact that patients with severe mental illness often had normal appearing brains on autopsy. With no identifiable physical or physiological pathology, it becomes difficult to diagnose or treat, and it is this challenge that partly explains the shifts within psychiatry at different points in history.

Somatic treatments allowed psychiatrists to use what they believed to be scientifically backed interventions that would produce cures in the form of patients restraining their own socially unacceptable impulses. Psychiatrists could now distance themselves from the moral treatment model of the 1800s which had come under attack due to its failure to produce cures, but also because it had failed to elevate the field to the clinical science it aspired to be. This is a common theme that can be seen in each transformative period within psychiatry. As the field adapts and finds new solutions to achieve restraint in patients, the old models of treatment are cast away. As will be explained in chapter 3, the same will happen to somatic treatment and psychosurgery as pharmaceuticals become the new solution.

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**Frontal Lobotomy**

Shock therapies were extreme, dangerous procedures, but the majority of hospital reports and journal articles reported impressive cure rates and deemed these treatments effective. Popular magazines like *Time*, *Scientific American*, and *Reader’s Digest* ran favorable features on shock therapy.\(^{58}\) It was during this time period that psychosurgery garnered more and more popularity in the US. Egas Moniz is credited with developing the prefrontal lobotomy procedure, claiming in his first report that “prefrontal leucotomy is a simple operation, always safe, which may prove to be an effective surgical treatment in certain cases of mental disorder.”\(^{59}\) The procedure was popularized in the US by Walter Freeman and James Watt.

Psychosurgery was heavily influenced by the budding field of neurosurgery, which had just recently been developed. Surgery on the brain was not a novel concept, but medical advances in bacteriology and anesthesia, along with the growth of neurology, made brain surgery more viable. In the US, Harvey Cushing was an especially prominent figure, helping to advance the field with new tools and techniques to make surgery safer. Freeman himself trained under French neurologists at the Salpetriere in the 1920s, and was heavily influenced by the work French neurologists were performing, especially with respect to interventional and surgical approaches.\(^{60}\)


\(^{60}\) Mical Raz, *The Lobotomy Letters: The Making of American Psychosurgery*, Rochester: University of Rochester Press, 2013, 17. American medical graduates often studied medicine in Europe if they had the means. France and Germany were popular destinations and helped inform much of the medical landscape in the US. Freeman was particularly interested in interventional neurology, being struck by minimally invasive procedures such as the cisterna magna puncture.
Freeman wrote extensively about the psychology of lobotomy and how severing the frontal lobes might lead to the end goal of treatment. Much like shock therapy, treatment and clinical improvement were evaluated in terms of behavior, or how well the patient could exercise self-restraint and readjust to society. Freeman explains this by writing,

The theory underlying prefrontal lobotomy is that severing the connections between the thalamus and the prefrontal regions brings about a decided lowering of the emotional responses that activate and energize the ideational process generated in the frontal lobes … There is thus, following prefrontal lobotomy, a redirection of the thinking process from the self toward the environment. The patient takes his cue from those around him. He is cheerful when they are cheerful.\(^{61}\)

Here we see how Freeman theorizes that lobotomy causes the patient to stop responding to the impulses from the self and instead interact appropriately with the environment.

Although the goal of restraint here is similar to the moral treatment period, the method is remarkably different. Lobotomy does not try to coax the patient into mental tranquility like the asylum, but rather acts in a physical, direct manner. Connections in the brain are physically cut away to promote a redirection of thinking. Despite the very medical and physiological theory behind the procedure, it is clear to see how such a drastic and direct procedure could later be construed as too extreme.

Freeman’s case reports and correspondence with patients and families reveal more about the importance of self-restraint in evaluating treatment success, sometimes to the extreme of being mentally blunted. For example, in a letter written to Freeman by a patient’s father about his son’s progress following lobotomy, the patient is described, “He has, of course, no emotional reaction whatsoever, so that he is spared of any mental

torment … We are naturally thankful that he does not have to suffer as he did prior to the surgery.”

In another letter, a patient’s father writes to Freeman asking about potential lobotomy for his son. He writes, “Therefore naturally I would like to consider any surgical procedure that would control the self-destructive tendencies in my boy. No matter what the outcome, the result could surely be no worse for us than the vision of this boy always being physically restrained …”

This example clearly shows how patients and families viewed lobotomy as the answer to impulsive behavior and a favored alternative to other modes of restraint.

Hospital reports reveal similar ideas of the therapeutic goals of lobotomy, and both psychiatrists and families share similar sentiments. At McLean Hospital in Boston, doctors describe a patient suffering from catatonia with “tenseness, depressive feelings, and feelings of apprehension.” After surgery, the patient’s husband wrote that the patient was now in a cheerful mood, doing the housework, shopping, and other domestic duties with good behavioral control.

Another patient was described before treatment as being paranoid, stubborn, and with a hostile personality. After surgery, she was described as “more friendly” and although the patient herself reported that she felt like her emotions

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62 Many of the letters to Walter Freeman and Freeman’s case reports come from the George Washington University archives. Mical Raz in her book, The Lobotomy Letters, makes extensive use of these archives as he examines how physicians, patients, and families viewed lobotomy and why the procedure became so popular. Bert Langer’s father to Walter Freeman, 1955.
63 David Gray’s father to James Watts, 1943.
64 Cited in Pressman, 257. Pressman drew upon patient files, including clinical notes, nursing records, and correspondence, from McLean Hospital
were “black and white”, she felt that this loss was more than compensated by the gain in comfort and ability to concentrate.65

The ability to restrain impulses applies not only to behavior, but also to thoughts that might cripple an individual’s ability to live a normal life. This is illustrated by one patient, who although being a well-adjusted housewife and mother in her forties, began to experience a decline due to severe depression, culminating in a suicide attempt. Throughout her hospitalizations, she continued to suffer from not being able to restrain her depressive thoughts, being described as “drenching herself with tears.” The patient underwent lobotomy, and soon after, she was described as “friendly and responsive, with a good deal of pleasure and spark.”66 The patient actually wrote to her psychiatrist,

> When I first came to the hospital I was in a room with no doors, no outlets. My only companions were Fear and Hopelessness. It was grim. Gradually throughout all of this time you have made me see for myself that particular room (which actually seems to have been of my own choosing) has doors. I am the one who must open them. I, myself.67

In this account, the patient describes how she now has control over her mind, being able to open doors for herself other than the depression that she had come to know. This was exactly the type of insight that psychiatrists sought in patients, the ability to restrain the self, whether it was the restraint of behavior or the restraint of maladaptive emotions.

**Backlash against Shock Therapies and Lobotomy**

Although the somatic treatments had received much fanfare and had been hailed as revolutionary, the 1950s saw a complete change in their perception amongst both psychiatrists and the public. In a major study published in the *American Journal of*
"Psychiatry, insulin shock was denounced as a method with no rational and an example of how dangerous the “it can’t do any harm to try” approach was in psychiatry.\textsuperscript{68} Controlled trials comparing shock treatments to placebo revealed that treatment actually resulted in longer hospital stays, with authors concluding that “coma therapy has been of little value in itself in the improvement of patients.”\textsuperscript{69}

Lobotomy did not fare much better. Advances in neuroscience had revealed the importance of the frontal lobes in the highest functions of human thinking, such as judgement, memory, and intelligence. A review of the literature in 1970 concluded that there is “little place for the standard bilateral prefrontal lobotomy”, finding that complications were too serious and common enough to outweigh any potential benefits.\textsuperscript{70} Psychiatrists now began to realize that lobotomy was too extreme of a procedure. Although the surgery might make patients more restrained in terms of their behavior, psychiatrists acknowledged that “there is no indication, however, that the operation really cures the patient’s disease. Rather it seems to produce a new emotional equilibrium on the basis of which he can function more satisfactorily.”\textsuperscript{71} Thus, although psychiatrists had found methods that produced self-restraint, these methods had gone too far on the spectrum. This type of self-restraint became very similar to the extreme physical restraints in the madhouse in that a patient’s freedom was taken away to alleviate their condition rather than provide a cure for the mental illness.

\textsuperscript{69} Joseph Lifschutz, “Insulin Coma Therapy: A Study of Results in an Army Hospital,” \textit{Am J Psychiatry} (1954): 466-469
The American public also began to reverse its perception of the somatic treatments, primarily because people felt that these therapies were too restraining and oppressive. Earnest Hemingway was one famous example when he wrote about his own ECT treatments, “What is the sense of ruining my head and erasing my memory, which is my capitol, and putting me out of business? It was a brilliant cure but we lost the patient.” Hemingway here captures the theme that psychiatrists had also begun to realize, that psychiatrists had gone too far in their attempts to control mental illness.

The 1960s witnessed the publication of novels like Ken Kesey’s *One Flew Over the Cuckoo’s Nest* and Janet Frame’s *Faces In The Water*, which provided scathing accounts of psychiatry, ECT, and restraint. Kesey’s book was particularly successful, becoming a movie that won five Oscar awards. Kesey had been an orderly at a psychiatric hospital in California, and provides an interesting look into the perception of psychiatric treatments as a tool of restraint. In the novel, psychiatrists use ECT not to treat the main character, but to control him. When ECT doesn’t solve the character’s behavioral problems, they turn to lobotomy. The film, released in 1975, emphasized the theme of oppressive psychiatry, with Jack Nicholson portraying the main character Randal McMurphy as he was subjected to the terrors of psychiatric treatment. The themes of oppression and restraint at the hands of psychiatrists tasked with keeping people in order permeated popular culture and affected the way psychiatrists themselves thought about their own profession.

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It was during this period that psychiatrists began to speak out against the direction the field seemed to be headed in. The 1960s saw the rise of anti-psychiatry\textsuperscript{73}, a movement that challenged the current practices in the field. At the forefront of this movement were people like David Cooper, Thomas Szasz, and R.D. Laing. Although they had diverse backgrounds and different ideas, most agreed that the medical model of psychiatry had overstepped its authority with measures like involuntary hospitalization, electroshock, and overuse of medications. Szasz in particular argued that psychiatrists should not have the ability to forcibly detain and treat patients for behaviors they believed to be “deviant” rather than pathological.\textsuperscript{74} Szasz believed that mental illness was simply a label that allowed psychiatrists to overstep the rights and liberties of patients. Laing similarly believed that psychiatrists falsely diagnosed mental disorders based on behaviors rather than observable pathology.

It was during this period that Foucault wrote \textit{Madness and Civilization}, where he argued that insanity is socially constructed, and psychiatry was a method to confine and restrain the insane so that accepted social values would continue being upheld. One of the central themes of anti-psychiatry in the 1960s was psychiatry as a form of social control and oppression. Behaviors deemed to be socially unacceptable or different were restrained, whether through ECT, lobotomy, or medications so that the social order would

\textsuperscript{73} Anti-psychiatry was a term first used by David Cooper in 1967. Cooper was a psychiatrist trained in South Africa and who practiced in London. Cooper, like many other proponents of the movement, argued that madness was not something to be controlled but rather a “permanent revolution in the life of a person … a deconstitution of oneself with the implicit promise of return to a more fully realized world.” See David Cooper, \textit{The Language of Madness}, 1980.

\textsuperscript{74} Thomas Szasz, \textit{The Myth of Mental Illness: Foundations of a Theory of Personal Conduct}, New York: HarperCollins, 1974. Despite being a US trained psychiatrist, Szasz argued that mental illness was not real in the sense that other diseases, like Alzheimers, were because there was no objective data to detect a mental illness. He was known for his libertarian views and spoke out against coercive practices in psychiatry like involuntary commitment, believing that they infringed upon civil liberties.
be upheld. Liang describes this by writing about schizophrenia as “one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed minds.”

Although the anti-psychiatry discourse made legitimate claims about psychiatry and oppression, what is often missed is the medical perspective of mental illness and the patient perspective. Many proponents of anti-psychiatry during the 1960s had no medical or psychiatric training, and so based their views more along philosophical lines rather than clinical practicality. While the meaning or utility of madness makes for interesting discussion, it does not lead to treatment. Psychiatrists had, however, become aware that in their goal to find scientifically backed treatments, they had gone too far on the spectrum of restraint. Lobotomy and the somatic treatments were effective in controlling behavior, but were too shackling on the mind much like the straightjackets and chains had been too shackling on the body in the madhouse. Psychiatry had to find an alternative, and one important solution was drug therapy.

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75 R.D. Laing, *The Politics of Experience*, New York: Pantheon, 1983, p. 107. Like Szasz, Liang believed that mental illness was not diagnosed on biological means, which made diagnosis too subjective. Along these lines, he also spoke out against using medications for psychiatric disorders. Despite these views, Liang did not associate himself with anti-psychiatry.
Chapter 3: The Biological Era

By the 1950s, American psychiatry was in the midst of another transformation. The decline of state hospitals had reached its peak, leading to questions about the utility and humanity of state institutions. This decline had started much earlier, and had already inspired several authors to speak out against what the asylum had become. One striking example was Alfred Eisenstaedt’s work photographing the Pilgrim State Hospital in 1938, one of which is shown below.

![Figure 7: Patient being restrained by two nurses. Alfred Eisenstaedt. (1938). Pilgrim State Hospital [photograph]. Retrieved from Ben Cosgrove, “Strangers to Reason: LIFE Inside a Psychiatric Hospital, 1938,” Time, 2014.](image-url)
A few years later, in 1946, *Life* magazine published “Bedlam 1946,” an exposé of two state hospitals in Ohio and Pennsylvania.⁷-six The images were striking at the time, especially given the time period right after WWII and the Holocaust.

These images harken back to the madhouse period, with patients in straightjackets and other contraptions designed to restrain. With such terrible conditions and the hopelessness of providing any type of treatment for the chronic mentally ill, psychiatry was not in a good place.

The 1950s, however, provided some hope for change as advances in pharmacology and neuroscience began to provide new tools. The introduction of chlorpromazine in 1954 for psychotic disorders in the US signaled a new era in

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⁷-six Albert Maisel, “Bedlam 1946,” *Life*, 1946. The original article included many photographs taken from the two state hospitals, and offers a scathing report of conditions.
psychiatry, and for the first time, psychiatrists had effective drugs on par with the antibiotics and vaccines of medicine that could produce real change in patients.

The chapter will use drug advertisements as a case study of how drugs were marketed and used as tools of restraint. Special attention will be paid to how drugs were advertised as a form of restraint along gender and racial lines, particularly drawing upon arguments made by authors like Jonathan Metzl and David Herzberg. The perspective of psychiatrists will be examined at the dawn of the “Decade of the Brain” of 1990, and examine how physicians had come to think about drugs and restraint. The chapter will especially draw upon the scientific literature of the period, namely the *American Journal of Psychiatry* and the *Archives of General Psychiatry* to obtain the psychiatrist perspective.

**Drugs as the Solution**

The rise of pharmaceuticals was changing the way doctors thought about and treated mental illness. The first drug introduced in the US was chlorpromazine (Thorazine) in the 1950s. For the first time in psychiatry’s history, doctors had a drug that could actually produce real and scientifically backed results. Thorazine was hailed as “unlocking psychosis.” The success of Thorazine encouraged the pharmaceutical industry to bring other drugs to the market. The “tranquilizers”, like Miltown and Valium, were introduced as anti-anxiety medications. Anti-depressants were developed in the late 1950s, with the monoamine oxidase inhibitors and tricyclic antidepressants.

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77 Chlorpromazine, first approved in the US in 1954, is considered the first antipsychotic. Although the drug was associated with many side effects, it was widely used for its effectiveness in treating psychosis and is even on the WHO List of Essential Medicines. For more on the history of chlorpromazine, see Francisco Lopez-Munoz, “History of the Discovery and Clinical Introduction of Clorpromazine,” *Annals of Clinical Psychiatry* (2005): 113.

Psychiatric drugs were much more than a solution to anxiety or depression however. As authors like Metzl and Herzberg have argued, psychiatric drugs hold a much deeper weight and meaning in American culture, being closely tied to the social problems and struggles faced by certain groups in the US, like the white upper middle class of the 1950s and 60s, or the working, professional women of the 1990s and 2000s.\(^79\) Herzberg sums this up by writing, “From Miltown to Prozac, critics have pointed to psychiatric medicines as both the symbol and the substance of deeply gendered crises in white middle-class culture.”\(^80\) Therefore, social problems in American culture like marital discord or trouble with “fitting in” became pathologized, prompting the need for treatment with medication. Similarly, counter-culture movements like the feminists or the Black Panthers became associated with psychiatric disease and drugs. It is within this context of the relationship between society and drugs that pharmaceuticals were advertised and employed.

With drugs as the answer to many of society’s problems, we can begin to examine how drugs were used as tools of restraint. In the second transition period in the early 20\(^{th}\) century, psychiatrists had seen their domain extend as judges of socially acceptable behavior. Drugs helped to further extend this domain as psychiatrists could now identify troublesome behaviors in society and help patients restrain themselves. Psychiatrists may

\(^79\) See Jonathan Metzl, *Prozac on the Couch* (Durham: Duke University Press, 2003) and David Herzberg, *Happy Pills in America* (Baltimore: Johns Hopkins University Press, 2009). Metzl argues that the paradigm shift in psychiatry from psychoanalytic to biological is not as clean cut as typically portrayed. He examines the ways in which psychiatric drugs were used along psychoanalytic lines, or as he puts it, ‘Assuming a move from Freud to Prozac, in other words, precludes the awareness of Freud as Prozac.’ Both Metzl and Herzberg use representations of medications in American print culture to examine the social underpinnings of psychiatric drugs.

\(^80\) Herzberg, *Happy Pills in America*, pg 8.
have abandoned somatic treatments and lobotomy, but the goal of achieving self-restraint in troublesome patients remained the same.

*The Language and Imagery of Restraint*

The following four advertisements show how drugs can be used to restrain socially unacceptable behavior from women, especially from the perspective of men. All four feature women as the main character, but noticeably feature the men or children as the ones suffering. Figures 9 and 10 for example, show the doctor and husband unable to deal with the woman’s behavior, and the drug is presented as the tool to control and restrain that behavior. In addition, these advertisements were published in psychiatric journals for psychiatrists, which illustrates how psychiatrists viewed and talked about the relationships between behavior, gender, and drugs. To a psychiatrist, the association between anxiety and women was clear and understandable, hence why companies could market an anxiety drug using these associations. The advertisements also use the language of restraint to appeal to the need for the psychiatrist to provide treatment. Many ads, including the ones in Figures 9 and 11, state that the drug helps restrain difficult behavior so that the patient may properly engage with the psychiatrist in therapy.
Figure 9 offers an interesting example, with a female patient in the foreground appearing worried, stressed, and hopeless clutching her necklace. In the background is the psychiatrist with his white coat and medical degree behind him, looking calm and confident. Clearly, the woman’s behavior and affect are unsatisfactory, and the ad highlights in the text how Deprol can reel in those unwanted behaviors. The ad states that Deprol can “reduce oppressive despondency and reduce self-hostility,” allowing the patient to open up more and participate with the doctor in psychotherapy. The image portrays the doctor as someone trying to help, and the patient needs something, like Deprol, to push her along so that she can restrain her anxiety and “self-hostility” and accept the doctor’s help. This figure really highlights the “self” aspect of behavioral restraint, because it is not the doctor locking the patient in an asylum or operating on the patient’s brain, but rather the patient, with the help of a drug, controlling their own thoughts and behaviors.
Figure 10 shows a more outright example of drugs as tools of restraint. The ad shows an older woman looking angry and annoyed, yelling at her husband who is sitting down calmly eating. The hostility is clear in the picture, and the text explains how Mellaril, a tranquilizer, reigns in this hostility by relieving agitation and anxiety. The choice to portray the woman as hostile and the man as the victim speaks volumes to which gender was considered the problematic one. It also serves to associate the psychiatric disorder (anxiety) with both the gender and the behavior. Anxiety thus becomes a female problem highlighted by unacceptable behaviors like agitation.
Figure 11 reveals how drugs may be used to control a woman’s “neurotic sense of failure, guilt, or loss” to obtain the ideal of marriage. The ad shows how “Jan” has been with men all her life, but is now struggling because she “may never marry.” Valium is supposed to help her restrain her neurotic behavior and achieve the goal of marriage.

Once again, the ad associates the psychiatric condition with gender roles and the behavior. Jan is a woman, and so her most important relationships are with male figures, notably either her father or a husband. Her failure to find a husband is unacceptable, causing her to have anxiety, apprehension, and agitation. Valium is the solution to these behaviors, with the ability to help her restrain these behaviors so she can participate in therapy.
Figure 12 is a more recent advertisement for the anti-depressive Effexor. The ad places the happy mother with her child as the largest image with the caption, “I got my playfulness back.” This signals to the consumer that the drug allows the woman to once again enjoy the joys of motherhood by controlling her depression or anxiety. Unlike the previous ads mentioned, there is no psychiatrist in this picture, revealing the shift in the relationship between psychiatrist and restraint of behavior. Here, depression is considered socially unacceptable because it prevents the woman from doing her job as a mother. Effexor serves to restrain that depression, helping the woman fulfill her motherhood.

Advertisements also used the language of restraint in targeting unwanted behavior in men.
Figure 13 is an ad for Taractan from 1966. This image reveals several differences from Figure 9. The male patient is in the background, appearing anxious, emotional, and unkempt with his tie loosened. The man in the foreground, the psychiatrist, looks not calm, but concerned with his arms crossed and appearing pensive. The ad classifies the patient as anxious and depressed, with his display of emotion being something that needs to be controlled with medications. In other words, the patient must restrain himself and his emotions in order to be “healthy” again.
Figure 14 is a more extreme example and also touches upon the relationship between drugs and race. The ad shows a black male, clearly agitated with teeth clenched and fist raised and states “Assaultive and Belligerent.” The text states that Haldol controls disruptive and aggressive behavior and produces a “sensitivity to the environment that allows more effective use of the social milieu and the therapeutic community.” Once again, we see how behavioral control is linked to the drug, Haldol, and how this self-restraint on the part of the patient allows for treatment. This is very similar to how lobotomy allowed patients to return to their family in better behavioral control or how the asylum could allow patients to regain their faculties once taken out of stressful cities.

Worth noting is the date (1974) that the advertisement came out, which was a period filled with racial strife and the target audience, which were psychiatrists trying to treat these types of patients. The choice to use a black man as an example of belligerence is interesting because it provides a glimpse into the relationship between drugs and social
control. As Metzl argues in *The Protest Psychosis*, schizophrenia became a diagnosis increasingly applied to black Americans in the late 1960s. Black men were admitted to hospitals and prescribed antipsychotics for things like participating in civil rights protests, riots, or simply being involved with the civil rights movement. Studies from the National Institute of Mental Health found that black Americans had a 65% higher rate of schizophrenia than whites, and later studies from the 80s showed similar disparities, finding that paranoid schizophrenia was diagnosed up to 7 times more often in black men. The *DSM-II* actually ties the disease not only to aggression and hostility, but to men who don’t follow the rules. Anti-psychotics were seen as the solution to this type of schizophrenia, allowing unacceptable behaviors to be restrained in the name of medicine and treatment.

**The Psychiatrist Perspective on Drugs as Restraint**

Examining the way drugs were advertised to psychiatrists and patients allows us to see the imagery and language that combined restraint and medication. By the 1970s and 1980s, advancements in drug development had given psychiatrists many drug options for a wide array of psychiatric diseases. How did psychiatrists view the relationship between drugs and restraint? The main theme that emerges from the psychiatrist perspective is that drugs did help restrain behavior, but along biological lines. This is a different biology from the era of Meyer. Whereas Meyer had viewed mental illness from

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81 Jonathan Metzl, *The Protest Psychosis*, Boston: Beacon Press, 2011. Metzl used records from the Ionia State Hospital for the Criminally Insane in Michigan, a large asylum with an annual average of 2000 patients at its height. With deinstitutionalization in the 70s, the population fell to around 300, and the asylum transitioned to a prison. Metzl’s main argument revolves around the relationship between the diagnostic criteria of schizophrenia and the surrounding social environment of the 60s and 70s.

82 Office of the Surgeon General; Center for Mental Health Services; Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health (2001).

a more social perspective and talked about biology in the context of societal adjustment and behavior, drugs allowed psychiatrists to use a more brain based approach. For example, depression could now be characterized by imbalances in serotonin in the brain. Drugs helped treat a patient’s illness, thereby allowing them to restrain their own behaviors and impulses, making the patient healthier and safer. Now, by using drugs to target the biological basis of mental disease, psychiatrists could distance themselves from the theme of the oppressive psychiatrist shocking and lobotomizing patients.

The emphasis on biological psychiatry can be seen in how the APA transformed in the 1970s and 1980s. Under the leadership of Robert Spitzer, a task force was created to better classify different diseases and make diagnosis more evidence based. Spitzer was instrumental in making the psychiatric interview more focused, with specific questions being used to screen for disease rather than the open-ended approach used by psychoanalysts.\textsuperscript{84} Questionnaires still used today, like the Patient Health Questionnaire (PHQ9), were developed under this task force.

The modifications to the DSM offer an interesting look into how psychiatry and the idea of restraint had become more biological. \textit{DSM-I} was published in 1952, at the height of American psychoanalysis. The manual conceptualized mental illness along analytic lines, categorizing disorders like “psychoneurosis” and “conversion,” and uses analytic language to explain presenting symptoms. Homosexuality, for example, was listed as a psychiatric disorder and explained along Freudian concepts like “genital diminution fears” and placing the blame on parental practices like being too punitive toward early sexual behavior.\textsuperscript{85}

\textsuperscript{84} Scull, \textit{Madness In Civilization}, 389.
The *DSM-III* was released in 1980, and marked a noticeable shift away from the psychoanalytic basis of disease. The *DSM-II* had separated mental illness into neurotic and psychotic categories, with the neuroses being the domain of psychoanalysts. Spitzer worked to get rid of the neurosis category and improve the uniformity of diagnostic criteria. Whereas psychoanalysis pointed to an individual’s development and personal relationships, biological definitions could point to abnormalities in neurotransmitters and chemical pathways. This made the justification for restraint of behavior more powerful because doctors could point to biology and science as explanations. This also made categorizing illness easier, since individual factors were given less weight. Psychiatrists could now fit patients into distinct categories like mood disorders or psychotic disorders, and treat with the appropriate medications.

Advances in neuroscience bolstered the use of these categories. For example, experiments in the 70s showed that schizophrenia was linked to excess dopamine in certain areas of the brain, and antipsychotics worked by blocking dopamine receptors.\(^8^6\) Thus, treatment could now be justified not just on blind efficacy, but on what was considered at the time clear neuroscience. Interestingly enough however, many of the same problems faced by prior treatment modalities arose with drugs. Ideas that arose out of this era, like the dopamine hypothesis of schizophrenia, were later challenged as neuroimaging and genetic studies revealed a deeper complexity. There has also been a growing literature describing the efficacy of psychotherapy modalities, like CBT and DBT, over the use of drugs alone.\(^8^7\) Just like with moral treatment and the somatic

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therapies, psychiatrists continue to struggle with understanding that drugs do work but without understanding exactly why they work.

With the link between behavior and biology, psychiatrists could now claim their domain and determine which behaviors were acceptable and which were unsafe and unhealthy for the patient, allowing doctors to provide treatment. The literature published at the time around the treatment of behavior reveals how psychiatrists perceived the use of drugs to achieve the goal of self-restraint. One major shift was the increasing involvement of the patient in treatment. Drugs allowed psychiatrists to distance themselves from the restraint of behavior because they could now point to the medicine as allowing the patient to correct their brain chemistry and restrain their own behavior. This shift can be seen in the way doctors handled aggressive patients. With patients who are acting violently or aggressively, doctors and staff attempt to work with the patient to get them to agree to take medication by mouth rather than physically restraining and secluding them. In doing this, psychiatrists can avoid treating patients against their will.

Defining behavior as safe or unsafe also legitimized the use of medication. In many of the research studies done on neuroleptics used for behavioral purposes, psychiatrists looked at safety as a primary outcome. One study concluded that, “Acute psychotic states may be associated with agitated and belligerent behavior that requires immediate medical attention to reduce the risk of injury to self or others and to provide greater comfort.” Drugs were also viewed as a more viable alternative to physical restraint and seclusion, which by this period was something that doctors wanted to avoid.

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The use of the term “chemical restraint” was actually a point of contention within the field because medication was viewed more as “treatment” rather than “restraint.” In a letter to the editor in response to an article on aggression in child psychiatric hospitalization, one psychiatrist goes as far to state that, “Restraint is never a target goal in psychotropic medication” and that psychotropic medications are used to restore mood, decrease panic, and improve cognitive abilities to restore reality testing.\(^{90}\) Here we see how medication could be viewed as a tool to help patients realize their own disease and control their own behavior.

A 1980 article titled “The Psychiatrists Double Bind: The Right to Refuse Medication” sums up this view by stating, “The psychiatric profession contends, with much evidence, that the use of antipsychotic medication and, on occasion, seclusion are, much like the law, ‘wise restraints which make man free.’ They can get many people over the hump of severe immobilization and free them up for discussion of their problems.”\(^ {91}\) To psychiatrists, medication was viewed as a conduit to achieving self-restraint in the patient, to give them insight into their disease and control their behaviors accordingly.

By the 1990s, new brain imaging techniques, manual based psychotherapies, and drug developments helped fuel the growth of biological psychiatry and psychopharmacology. Psychiatrists could now point to specific areas of the brain and neurochemistry to explain disease and had a growing evidence base to manage and treat patients. 1990 signaled a new era for psychiatry, marked by the “Decade of the Brain,” an

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initiative involving the NIMH and Library of Congress to “enhance public awareness of the benefits to be derived from brain research.”\textsuperscript{92}

However, the de-institutionalization of asylums led to more challenges for psychiatry, especially as the 1980s and 90s saw a rise in the prison population. Population studies began to show that prisons became holding grounds for the mentally ill, with some states having more psychiatric patients in prison than hospitals.\textsuperscript{93} In addition, drugs did not prove to be simple solutions. The majority of psychiatric drugs carry significant side effects and complications that make long term use difficult for patients. Efficacy is not clear cut either, and psychiatrists continue to struggle with the “why” question of treatment, much like they struggled with why moral treatment or insulin shock worked.

\footnotesize\textsuperscript{92} George Bush, \textit{Presidential Proclamation 6158}, filed with the Office of the Federal Register, 1990.
\footnotesize\textsuperscript{93} E. Torrey (2010), \textit{More Mentally Ill Patients Are in Jails and Prisons than Hospitals: A Survey of the States}, Retrieved from \url{www.treatmentadvocacycenter.org}. 
Conclusion

Having examined the three periods within psychiatry’s history in the US, a common thread is revealed. Namely, the goal of self-restraint perseveres even as psychiatry does its best to distance itself from its previous manifestations. Moral treatment arose as a solution to the physical restraint of the madhouse, with the philosophy that cultivating a patient’s mind would help the patient control their behavior. When the asylum system failed to produce results, a new solution arose in the form of shock therapies and lobotomy. Backed by science and psychiatry’s new role as judge of behavior, these methods aimed to replace the asylum but employed a similar philosophy: shock the body or cut the brain in order to facilitate self-restraint of behavior in a socially acceptable way. When these methods failed to produce results, pharmaceuticals arose as the solution. Although now considered a biological and clinical science far superior to methods like insulin shock and lobotomy, drugs were used for the same goal, the facilitation of self-restraint.

All three modalities, despite being very different in scope or efficacy or scientific/clinical basis, allow the psychiatrist to be the judge of behavior and determine how much self-restraint a patient should exercise. Drugs themselves, for example, carry with them a cultural and social weight that affects how they are prescribed and used. This is seen in situations such as a professional mother needing Prozac to deal with her unacceptable feelings of depression over valuing her career over family or a college student needing Adderall to deal with uncomfortable feelings of social press to succeed in school. With the psychiatrist at the center of what may be deemed socially acceptable behavior, it is understandable why the field may face skepticism and stigma.
One major conclusion to draw from this is understanding why psychiatry as a field has had to transform itself to keep up with changes in society. As treatments like asylums or lobotomy become too restraining and too controlling from the patient and societal perspective, psychiatry has to find new solutions. Even with drugs, backed by biology and neuroscience, society has pushed back when treatment crosses the boundary of control. For example, the 1970s saw resistance to popular tranquilizers like Valium as its potential for addiction became more apparent.\(^\text{94}\) Valium, once considered “mother’s little helper” and one of the most prescribed drugs in the US, came under attack for not only being addictive, but also for serving as an oppressive tool that restrained women’s rights as it kept them in the home. Although drugs have become more steeped in clinical science, society continues to question how far drugs go on the realm of restraint. We have to look no further than Tom Cruise’s rant on psychiatric drugs on the Today Show in 2005, where he claimed drugs are “dangerous, mind-altering antipsychotics” that mask the problem.\(^\text{95}\) Although Cruise hardly speaks for the majority, his sentiments speak to the growing public concern that Americans are increasingly “drugged up.”

Viewing the evolution of psychiatry through the lens of restraint, we can see the complex relationship between psychiatric care and the social and cultural fabrics of society. This is important within the fields of psychiatry and history of medicine in order to understand and provide context into why psychiatric care has changed and transformed throughout history. A high school student today who has trouble focusing in school might

\(^{94}\) Herzberg, *Happy Pills in America*, pg 13. Valium is an anti-anxiolytic drug, or as referred to in the 60s and 70s, a minor tranquilizer. It had been one of the most popular drugs in the US until it was discovered to be addictive. Popular backlash was so great against the drug that even the Rolling Stones made the drug the subject of the song “Mother’s Little Helper,” where they sing about a little yellow pill that helps a mother get through her busy day.

\(^{95}\) Today. (2014, June 2). *Tom Cruise’s Heated Interview With Matt Lauer*. Retrieved from https://www.youtube.com/watch?v=tFgF1JPNR5E.
be treated differently than a student from the 1940s with similar troubles, not only because of increased diagnostic knowledge, but because of what society expects from that student. As society changes, the concept of self-restraint changes, and psychiatry needs to be aware of this in order to adapt appropriately. A prime example of this is homosexuality. In the 50s and 60s, homosexual behavior was something that needed to be restrained, and even appeared in the first few versions of the *DSM* as pathologic. Today, gender fluidity is more acceptable and no longer something that a patient would need to restrain. Psychiatry needs to be aware of this in order to keep pace and prevent the rise of stigma or backlash like what happened to the asylum in the 1900 or lobotomy in the 1950s.

In the present, psychiatry is continuing to evolve as a field and has grown to encompass a wide range of clinical scope. Trainees in psychiatry today at most academic institutions learn not only about neuroscience and psychopharmacology, but also about psychotherapy and psychoanalysis. The manual based therapies, like CBT and DBT, have developed extensive evidence and have opened the way for multidimensional approaches to treatment. These new approaches bring a different element to self-restraint. Mindfulness based approaches, for example, put a much higher responsibility on the patient to be more self-aware and self-reflective of their emotions and behaviors. Biofeedback has become increasingly used as a way for patients to monitor their own pain levels and learn how to balance pain with stress. These therapies place more power in the patient’s hands, but only if patients want to change. Restraint continues to be pervasive because of the question around who decides which behaviors or thoughts are healthy and which ones are not.
It will be interesting to see how the concept of restraint continues to evolve as psychiatry becomes more multifaceted, and in which direction society heads in terms of socially acceptable behavior. Challenges such as institutionalized racism, growing disparities between socioeconomic classes, and a huge prison population will make for interesting questions for psychiatry and the role that psychiatrists may play in complex social issues and questions. It is also important to keep in mind who is most restrained. Access to healthcare is different in different parts of the country, and while those with the ability and means may be able to access new treatments, others might not be able to. In the current political climate, access to healthcare is a looming issue, and will affect how we view restraint in the future. For example, while an individual with the means to access psychotherapy and longitudinal care might live a fulfilled and mentally healthy life, another individual without the same means may face prison time for their actions under the stress of mental illness. These inequalities within healthcare are something to pay attention to as the field continues to change and adapt. As psychiatry prepares for this, it is important to remember its history and how the concept of restraint has affected how the field has been challenged and how it responded to those challenges.
Appendix A

Figure 1: Benjamin Rush’s ‘Tranquilizing Chair’, illustrative sketch, taken from University of Pennsylvania University Archives
Figure 2: From Joseph Guislain, *Traité sur l’aliénation mentale et sur les hospices des aliénés* (Amsterdam, 1828).
Figure 4: Garden of the Hospital in Arles, 1889. Taken from Jan Hulsker (1980), *The Complete Van Gogh*, Oxford: Phaidon, pg 1687.
Figure 5: Taken from Ebenezer Haskell. (1869). *The trial of Ebenezer Haskell, in lunacy, and his acquittal before Judge Brewster, in November, 1868: Together with a brief sketch of the mode of treatment of lunatics in different asylums in this country and in England, with illustrations, including a copy of Hogarth's celebrated painting of a scene in old Bedlam, in London, 1635*. Philadelphia: E. Haskell. pg 20.
Figure 6: Taken from Ebenezer Haskell. (1869). *The trial of Ebenezer Haskell, in lunacy, and his acquittal before Judge Brewster, in November, 1868: Together with a brief sketch of the mode of treatment of lunatics in different asylums in this country and in England, with illustrations, including a copy of Hogarth's celebrated painting of a scene in old Bedlam, in London, 1635.* Philadelphia: E. Haskell. pg 20.
Appendix B

Figure 8: Albert Maisel, “Bedlam 1946,” *Life*, 1946.
Figure 9 (American Journal of Psychiatry 120 [1964]: xviii-xix)
Figure 10 (American Journal of Psychiatry 117 [1960-61]: xii-xiii)
35, single and psychoneurotic

The pretty girl is a local celebrity. She is known for her beauty and charm. A few years ago, she was in a relationship with a famous actor, but that didn't last long. She is now single and looking for love.

Valium (diazepam) can be a useful adjunct in the treatment of anxiety disorders, especially in the elderly. It is a short-acting benzodiazepine with a rapid onset of action and a short duration of action. It is available in tablet form and is commonly used to treat anxiety, insomnia, and other conditions.

Before prescribing Valium, please consult complete product information, a summary of which follows:

**Indications:**
- Anxiety disorders: Valium is indicated in the treatment of anxiety, especially in the elderly.
- Insomnia: Valium can be used to treat insomnia, especially in the elderly.

**Contraindications:**
- Hypersensitivity to benzodiazepines or related substances
- Liver disease
- Severe respiratory depression

**Warnings:**
- Use caution when administering Valium to patients with a history of alcohol or other drug dependence, or to patients with a history of suicide or attempted suicide.

**Dose and Administration:**
- The usual adult dose is 5 to 10 mg at bedtime, increased gradually as needed. The maximum daily dose is 30 mg.
- For pediatric patients, the dose is based on body weight (5 to 10 mg/kg/day).

**Side Effects:**
- Drowsiness
- Dizziness
- Nausea
- Headache
- Dizziness
- Confusion
- Slurred speech
- Impaired judgment
- Memory loss

**Interactions:**
- Valium can interact with other medications, including alcohol, and should be used with caution.

**Overdose:**
- Overdose can result in drowsiness, dizziness, confusion, and respiratory depression. Administration of an antidote, flumazenil, may be required.

**Precautions:**
- Valium should be used with caution in patients with a history of liver disease, respiratory disease, or a history of suicide or attempted suicide.

Figure 11 (Archives of General Psychiatry 22 [1970]: 290-291)
Figure 12 (Archives of General Psychiatry 58, no. 4 [2001])
A particularly useful therapy for the anxious patient with coexisting depression

Figure 13 (American Journal of Psychiatry 123 [1966]: xix-xlxii)
Figure 14 (Archives of General Psychiatry 131 [1974]: 732-33)
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