The Abolition of Seclusion. By T. O. Wood, L.R.C.P. Edin., M.R.C.S. Eng., Medical Superintendent of Dunston Lodge Asylum, Lecturer on Psychological Medicine in Durham University.

(Read at a Quarterly Meeting of the Medico-Psychological Association, held at Edinburgh, on November 30th, 1871.*)*

I have ventured to undertake the responsibility of bringing this important subject forward, in the hope that any little I can do may go some way towards abolishing a line of treatment which I consider to be unsatisfactory in its results and demoralising in its tendencies. Unsatisfactory in its results by its failing to raise the percentage of the recoveries of our patients, and in its being of no real benefit to those so treated; and demoralising in its tendencies by ever being before the attendants as a tempting means by which they may easily get rid of a troublesome patient to gratify their own idle propensities.

My reason for bringing this subject before you is because I have treated the insane without seclusion, and have found the treatment to be satisfactory; so much so that the recoveries of my cases so treated have been as numerous as those whose treatment included the practice I now condemn, and fully bear out the statistics which I shall presently place before you.

I feel confident as the system of non-seclusion becomes more matured, when it is more generally adopted by asylum medical superintendents—when seclusion becomes, like restraint, more completely a thing of the past, our asylum patients will be more speedily recovered, and their general condition ameliorated. The experiment having been tried, and, so far, found satisfactory, it behoves us to work it out more fully, so that by combined testimony we may be able to prove either its utility or its uselessness, and by a more extended trial we may get more decided data to go upon; and thus, having the experience of many, instead of a few, that experience may establish the principle that seclusion is not worthy of being considered a scientific means of asylum treatment.

Restraint was at one time deemed necessary; it has been

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abolished, or is now so very seldom adopted that it can scarcely be said to exist. Why may not seclusion be abolished, or at any rate be as rarely employed as restraint?

The subject is one more of practical difficulties than theoretical objections. It is the *how* to do it rather than the *why* that will be "the mountain in the way," and it will be my endeavour in this paper to point out how these practical difficulties are more apparent than real; more for want of trying, as I myself found out, than failure on trial. It has been said that, by placing a noisy and troublesome patient in seclusion, he is removed from contact with his fellow creatures, whose society produces or keeps up his excitement, and thus the order of the asylum is maintained with benefit both to the patient secluded and to those patients whose peace and comfort were disturbed by him.

Have we thought of the ultimate effect this seclusion has upon the mental condition of the patient? Is this mental quietude real, or is it only apparent? Are we not doing our patient a great injustice, and compelling him to suffer what ought really to be endured by those whose duty it is to manage, and not to shut him up to save trouble?

If shutting up a patient in seclusion does not produce any good effect upon the mental condition, if it only removes the ill effects of an unpleasant symptom from attendants and others, may not these ill effects recoil upon the patient himself, when a symptom is suppressed which otherwise should be allowed to run its natural course?

By secluding a patient, the subject of mental excitement, you remove from him all possibility of obtaining exercise, and that exhaustion of physical energy which otherwise would be expended, as, for instance, in rapid walking exercise out of doors.

This expenditure of physical energy is, I hold, the most valuable remedial agent in cases of mental disease with or without excitement, and a natural curative process which acts favourably, not only on the mind, but also upon the bodily condition of the patient, and which should always rather be encouraged, than suppressed by seclusion.

In the treatment of small pox you do not endeavour to suppress the eruption. You rather draw it out; in fact, you encourage it, so ought we to do in treating excitement as a symptom of mental disease; we should not suppress it by using seclusion, we should draw it out and judiciously encourage it, and so by allowing the necessary amount of

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physical expenditure both body and mind are improved. Thus you allow an evidence or sympton of the working of disease to go on, not checking the disease by suppressing a symptom, but guiding it in its manifestations, and directing it in the path of recovery. Again, by secluding a patient and preventing exercise, sleeplessness is incurred, requiring sleep to be artificially produced by sedatives. Dr. Maudsley's remarks on the subject seem to me to be more particularly applicable to such cases.

He says: "In brief, then, it seems to me that we are yet grievously in want of exact information with regard to the real value of sedatives in the treatment of insanity. Everybody gives them because there is mental excitement, and it seems a proper thing to subdue the excitement; but is it quite certain that it always is a proper thing to stifle excitement in that way?"* If, therefore, as Dr. Maudsley says, excitement may not properly be stifled in that way, why stifle excitement at all, either by seclusion or sedatives?

In fifty asylums, containing an average number of 28,673 patients, seclusion was practised 5,462 times, showing that for a little over one patient in every five seclusion was once employed. Whilst on the other hand we find that out of those fifty asylums, four, with an average number of 531 patients each, never used seclusion once during last year; and that in three asylums, with an average number of 827 patients each, and a total number of 2,481, the cases secluded only amounted to four, and that in one large asylum, wherein the number of patients was upwards of 1,400, the number of cases of seclusion was only one.

Are we not, therefore, justified in enquiring into this subject? I think that if so large a number of cases can be treated entirely without seclusion, and if in those asylums where seclusion *is not* practised the average number of recoveries is above that of asylums wherein seclusion *is* practised, we can only infer that seclusion is, as I said before, a practice to be condemned. And when I tell you that in one asylum the cases secluded were *one in six*, and that in another they amounted only to *one in* 1455, I think you will agree with me that there is a wide difference in the practice of our medical superintendents, that this difference ought not to be so great as it now is, and that seclusion is yet sadly too often employed. I think that air and exercise, with good

* "Insanity and its Treatment," by Henry Maudsley, M.D., F.R.C.P., "The Journal of Mental Science," October, 1871.

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food and careful attention during the day, and sleep at night, will do more for the cure of insanity than all the seclusion in the world. This requires a sufficient staff of attendants, and plenty of airing-court accommodation. I fully believe that any Superintendent can do without practising seclusion, and that after a fair trial the result will be so satisfactory as to encourage him to abolish it altogether. Good attendants are, no doubt, difficult to obtain, though how to get the better of this difficulty I must leave to abler heads than mine to devise. Airing courts are always more at the command of the Superintendent, and are only a question of arrangement, which we may consider to be no difficulty at all.

In conclusion, I venture to lay before you, as briefly as possible, the means I have adopted to attain my object, and I trust some good may come of my imperfect attempt to advance our treatment. Unfortunately, pressure of work has prevented me treating the subject more completely.

The means I have found most successful in treating patients without seclusion, have been—1st. The abstaining as much as possible from the employment of sedatives during the day, and only giving medicine as a sleep procurer at bedtime; 2nd. Taking care to have always a sufficient number of attendants on duty, so that excitable patients might be closely watched; and 3rd. Having a separate airing court set apart for the sole purpose of removing an excitable patient into before the excitement is allowed to run too high. By this means you remove your patient from contact with the patients who produce or keep up that excitement. At the same time every opportunity is offered for exercise and fresh air, which I need not mention as being much better for the patient thau seclusion.

During the last year I have had more troublesome patients under my care than I ever had before, and by these means I have been able to treat these cases and guide them to a most satisfactory convalescence. More particularly I may mention, among many, one patient, a violent epileptic, who, when he felt himself becoming excited, requested to be placed in the separate airing court, and by this means he walked off his excitement alone, with benefit to himself and his fellow patients. I have now abolished seclusion altogether, and as yet have had no cause to regret having done so, the recoveries of my patients for the last year amounting to 52.6 per cent., which is, I believe, considerably above the average result of asylum practice.

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