question which we need not now consider. I am inclined rather to dwell on the greater prominence given to conscience and bodily disease by Euripides, as distinguished from the more supernatural view taken by Æschylus. In this, as in all his other religious and philosophical views, he was more illogical than his two fellow-dramatists, simply because he more thoroughly represented the mind of his day, when polytheism was dying out, and no other system was prepared to take its place. But the position in which Euripides expressly places conscience in the history of Orestes is worthy of his noblest title. He is a mark for the scorn of Aristophanes, as the friend of Socrates;—as the disciple of the man who could teach his fellow-citizens, that, though their religious systems were failing, and their intellectual culture was vanity, they could look to the approval of their own consciences for their highest reward here, and for the pledge of a still greater hereafter.

On the Proposed Abolition of Seclusion. By T. L. Rogers, M.D., Medical Superintendent of the County Asylum, Rainhill.

(Read at the Annual Meeting of the Association, held at Edinburgh, July 31st, 1872.)

A paper having been read at one of the quarterly meetings of the Association, on the "Abolition of Seclusion," which paper was subsequently published in the "Journal of Mental Science," I am induced to bring the subject before the General Meeting of the Association, with a view to elicit the opinions of members upon the subject.

In doing so I am at a disadvantage in this respect, that I am in entire ignorance of the opinions that were expressed in the discussion which followed the reading of the paper; and hence what I am about to say may, for aught I know, have been better expressed at that time; but as the paper is published alone and without any indication of the general opinions of the members who were present at the meeting, I am desirous of placing on record my own views on the subject, and also of hearing the opinions of those members of the Association who do not accept the views of the author of the paper.

The "Abolition of Seclusion" appears to have been recommended as something new, and which required only to be

more fully known to be generally adopted by the majority of medical officers of "hospitals for the insane."

My purpose is to show that the idea is not novel, and that the disadvantages of the treatment recommended more than counterbalance the advantages. I go further, and maintain that seclusion, rightly employed, is not only a safe and expedient, but also a rational and scientific mode of treatment in certain cases of mental disease.

The idea is not novel. Many years ago seclusion, both by day and night, was entirely abolished at Fisherton House Asylum. When I visited that establishment in 1861, there was only one separate room in the house which was allotted as an indulgence to a member of our own profession, who was confined there, and this was done when there were at the time nearly 300 criminal lunatics in the Asylum, many of them being patients of the most violent habits and propensities.

Although I could not but admire the energy and determination displayed by the proprietors of that establishment in having so resolutely carried out their purpose of proving that seclusion could be superseded, I was not the more satisfied that the plan was expedient or desirable.

For my own part I see no difficulty in the "how" to abolish seclusion, but I see many reasons "why" the system should not be abolished. Assuredly if I considered seclusion injurious to patients I should not employ it, and here I must digress a little to protest against the too frequent habit of medical superintendents and others of laying the blame of anything of which they disapprove on their attendants.

There is an old adage about a certain class of workmen who complain of their tools, which holds good in the case of attendants. When superintendents complain of the idle propensities of their attendants, it reminds me of the chronic martyrdom which a certain class of ladies suffer from the behaviour of their servants, and seems to indicate either that they themselves are deficient in that knowledge of mankind which enables one man to govern his fellow men, or that they expect a more faithful and self-denying attention to duty than they ought to expect, having regard to the agents they employ.

If they were occasionally to ask themselves how they would act under all the temptations and provocations to which an attendant is exposed, if they bore in mind the fact that few attendants have had the benefit of any special training, and that they lack the advantages of education which they them-

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selves possess; and reflected that after all with all their advantages, it is just possible that if they were to change places with their attendants they themselves might fall short of the standard of excellence they had set up, I think we should hear less of the shortcomings of attendants.

My own conviction of the value of seclusion in the treatment of insanity has increased of late years.

It is many years since the alternative of active walking exercise in place of seclusion in cases of acute mania was strongly advocated, and this practice, the author of the paper before alluded to, seems desirous to see revived. A prominent advocate of this practice was a late member of the English Lunacy Board, himself previously a distinguished superintendent of a large asylum, and I certainly gave the practice a fair trial; but the result was unsatisfactory to myself, and, I believe, disadvantageous to my patients.

Indeed, I cannot see on what grounds but a purely psychic theory of insanity, such a practice could have ever found favour.

Let us picture a patient admitted into an asylum in a state of acute mania—the pulse from 100 to 120 or more, temperature over 100°—tongue very probably dry, and all the other symptoms of exhaustion present, which indicate prolonged mental excitement, with most probably absence of sleep, and an insufficient quantity of food for several days previously; let us leave the mental symptoms out of the question for the present, and suppose a physician, called upon to treat such a case, without having ever heard of such a disease as "mania," and consequently to be guided by the bodily symptoms alone —would anyone in his senses say "the patient wants exercise—walk him out with a nurse?" Would he not rather say, "Whatever the disease may be, the symptoms remarkably resemble those of fever—we will at all events treat him as such, and keep him as quiet as possible, and in bed," and because the disease is labelled "acute mania," is he to adopt a diametrically opposite mode of treatment?

Although we have indeed lately heard it laid down as a principle by a very high authority on medicine that "we must indeed treat the disease and not the symptoms,"* I am, nevertheless, fully convinced that the scientific progress of the treatment of cerebro-mental disease has been more retarded by a too close application of this rule than by anything else; that too much attention to the psychic and too little to the

* See Dr. Wilk's Lecture, *Lancet*, February, 18th, 1871.

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physical symptoms have been the main obstacle to a rational system of therapeutics in insanity.

It has been calculated that an increase of temperature of five degrees above the normal standard of the blood is equivalent to the work of lifting the body vertically one mile.

Those who advocate strenuous bodily exercise in acute mania must surely act on the principle of *similia similibus curantur*, but to me it appears more like what is popularly known as "burning the candle at both ends."

I do not undervalue the beneficial influence of exercise in the treatment of insane patients, which, like employment, has been found to be of the greatest service in the experience of all who have had the care of the insane, in cases in which it has been judiciously employed—that is on the subsidence of the more acute symptoms; but the more I see of acute mental disease, the more I am convinced of the value of simple rest in bed in the earlier stages, and I have made it a rule in my own practice that every patient on admission shall be kept in bed for the first day at all events.

Even the simple rest gained by lying in bed, together with the maintenance of an equable external temperature, and regular feeding, will often effect a material improvement in a patient's condition, without other treatment.

With patients in a maniacal condition, this keeping in bed implies keeping them in seclusion, for I am strongly opposed to the practice of keeping patients in bed by the coercion of an attendant or attendants employed to constrain their movements; believing that the physical efforts of patients to oppose this species of restraint, and the mental irritation caused by the constant opposition to their actions, are far more detrimental to their well-being, both physical and mental, than the passive state of seclusion; and to the objection that may be raised, that by keeping a patient in seclusion, you cannot ensure his remaining in bed, or clothed, I answer that you can at all events ensure an equable temperature, soft material to surround him, and a limited amount of movement.

In fact, so far from wishing to abolish seclusion, I am so much impressed with its value in the treatment of recent cases of insanity, that I have lately had several separate rooms prepared with a lining of kamptulicon cemented on boarding about seven feet high, the floor of the rooms being covered with the same material, and an additional narrow window being placed above the reach of the patient to admit of a certain amount of light when the shutter of the larger

window is closed. These rooms are ventilated, and artificially warmed in winter, by air admitted from shafts opening directly into the airing courts, and which passes through flues containing hot-water pipes, the entrance of the shafts being governed by Arnott's valves, which prevent any back current of hot air, the exit for the respired air being into a flue at the top of the rooms. (In fact, the same kind of arrangement that was advocated some years ago in a paper that occasioned much controversy at the time, with this addition—that my patients are provided with bedding and clothing.)

To carry out the principle of non-seclusion in its entirety, the use of separate rooms should be abolished by night as well as by day, for to a sleepless patient the long hours of the night are probably even more wearisome than those of the day; but what rest is to be enjoyed by convalescing patients, when those suffering from acute mania are occupying the same room?

It seems to be assumed that mental excitement in acute mania is a given quantity, which must sooner or later be expended, and that if this can be converted into muscular force and expended by trotting patients round an airing court, so much the better; but I am unable to perceive the truth of either of these hypotheses. On the contrary, maniacal excitement appears to me to feed itself, and probably most physicians must have observed (especially in the case of excitable children) the development of great mental excitement—in some cases amounting almost to delirium—from the increased rapidity of the circulation produced by great muscular exertion in play.

It may be said that this is due as much to the exercitation of the mental emotion as to the muscular exercise; but, admitting this, it at least proves that muscular exertion does not allay it. And it will be probably in everyone's experience that great muscular fatigue induces a condition which is inimical to sleep; and I suspect that in cases of acute mental disease a corresponding ratio might be traced between the muscular treatment and the number of deaths from exhaustion.

I could quote numerous instances in which I have given a fair trial to both methods of treatment, but I will instance two only by way of illustration of the positive good effects of seclusion.

The first case, admitted some years ago, was that of an extremely maniacal patient, whom I regularly sent out in

charge of one or two attendants to walk in the asylum grounds; but she was so extremely unmanageable, tearing her own clothes and those of the attendants to shreds, and obstinately refusing to do anything, or go anywhere, as she was wished to do, so much so that she had to be carried into and out of the ward (there being at the same time so much method in her madness that she would tell the attendants that they were paid to attend to her, and she would do as she liked), that I eventually gave up this plan of treatment, and ordered her to be kept in seclusion, when she soon began to improve, and is now a fairly well-behaved chronic lunatic; but I am strongly inclined to believe that if seclusion had been employed from the first that the result might have been more favourable.

The second case, admitted last year, was that of a strong, robust man, who was suffering from melancholia, and had previously attempted to cut his throat. He was kept in bed on account of the wound in the throat (which was but slight) with an attendant to watch him day and night, but he was in such a state of panic from the delusion that people were following him, that he on two occasions sprang up suddenly and attacked other patients who were sleeping in the same room, overpowering the attendant in charge, so that I considered the risk to be less in placing him in a single room, and that probably he would be in less dread than when in a room with other patients. He was accordingly placed in a padded room in a bed on the floor, where he rested perfectly tranquil and recovered in a few months.

Of course two cases prove nothing, any more than one swallow makes a summer, but they may be taken as illustrating the advantage of seclusion. In several recent instances I have observed that patients, who when out of doors were excessively excited, rushing about in the wildest manner possible, and were never still for a moment, when placed in seclusion would rest tranquilly, and also take their food better than when taking exercise.

Dr. Wood refers in his paper to a high percentage of recoveries as proving the efficacy of the system of non-seclusion, but I could refer to a still higher rate in an asylum where the number of seclusions was unusually large.

It was a remark attributed, I believe, to Canning, that "nothing was more fallacious than figures except facts," and in asylum statistics a mere statement of the number of recoveries, without any reference to the age,—to the length of

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time insane,—and to the nature of the mental affection of the patients admitted, proves very little.

I can conceive it to be quite possible for a physician to abstain altogether from giving any medicine, and yet be able to shew a very satisfactory table of recoveries; but would anyone argue from that that all medicine was useless, and if useless probably actually injurious?

I have thus far treated of seclusion as a remedial agent in the treatment of acute mental disease, and have endeavoured to shew that it is, under proper medical supervision, not only a safe and expedient, but also a rational mode of treatment, and one that it would be very unwise hastily to discard. I will now consider its employment, not so much as a curative agent for the exclusive benefit of patients for whom it is employed, as for the greater comfort and advantages of others.

In cases of recurrent mania, in which destructiveness, violence, and general excitement predominate, its employment is very beneficial, not so much for the patient himself as for the benefit of others. In the case of women especially, who suffer exacerbation at the menstrual period, and whose actions and language are at such times frequently libidinous and obscene, a short period of seclusion, whilst unattended by any detriment to themselves, relieves other patients from much that is extremely objectionable. It is not an edifying spectacle to see an excited female displaying her mental degradation before others; and I know nothing more distressing than to see young and well-conducted girls exposed to the disgusting language and actions, which are, unfortunately, more frequent amongst insane woman than those of the opposite sex. Such exposure cannot but be detrimental to the morals of respectable girls, whose interests ought to be considered as well as the supposed interests of those who are probably beyond the means of cure. Admitting that it is part of the duty of attendants to endure exhibitions so degrading, it cannot be held that other patients should also have to endure this, in addition to their mental affliction, and it is scarcely possible or desirable always so to classify patients as to protect the more innocent from the impurity of the more degraded.

In all establishments where many human beings are congregated together, it will be admitted, I presume, that it is essential for the wellbeing of all that some amount of order and discipline should be maintained, and the common mode of enforcing this is by a system of rewards and punishments.

Now if this is necessary in an establishment of sane

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persons, it is equally so in one for the insane, for I presume that no physician, at least, will maintain that because men and women are insane, they are therefore always quite incapable of appreciating the difference between right and wrong.

It is obvious that the means that may be adopted in a public school, for example, for maintaining discipline are inadmissible in a lunatic asylum, and yet, if the turbulent and quarrelsome are to have all their own way, it will be to the injury and disadvantage of the peaceable and inoffensive patients.

The ordinary indulgences that are available in an asylum are inadmissible, either by being granted or withheld, to induce order amongst those disposed to be riotous. In few cases is it advisable to reduce the diet of a patient, and so repressive measures are almost limited to the administration of drugs or to seclusion.

Now to employ drugs as a punitive agency I hold to be a prostitution of medicine, and what I may call the vicarious use of narcotics, viz., giving A, who is excited and noisy, but quite incurable, a narcotic because he disturbs B, is almost as bad; and I maintain that where one patient acts in such a manner as to cause discomfort and annoyance to others, it is perfectly legitimate and justifiable to seclude him or her—of course, under medical authority—for it is idle to assume that any attendant, however good he or she may be, will at all times be able to control all patients who may annoy others, and the alternative suggested of sending every violent patient into a separate airing-court, besides requiring in a large asylum an extensive series of airing courts, and favourable weather for their use, and a large staff of attendants, incurs the risk of personal encounters between attendants and patients which it is always desirable to avoid.

I am unable to perceive the injury, either mental or bodily, that a patient can suffer from short periods of seclusion under medical supervision, and I consider the notion of suppressed mental excitement recoiling on the patient himself as altogether apocryphal.

Some time since a sagacious suggestion was made in a medical journal, that with a view to remedy the supposed delinquencies of Asylum Medical Officers, the Superintendents should be selected from the general ranks of the profession, any special experience being held to be a disqualification, rather than otherwise.

Let us imagine a person appointed as Medical Chief to a large Asylum, who had never seen a lunatic professionally, but who had thoroughly posted himself up in the literature of insanity, and relied on his knowledge acquired by reading to direct his practice.

In the first place he would find that mechanical restraint was held (or professedly held) as an accursed thing, and not to be thought of in the modern treatment of insanity. Then he would hear from an eminent authority, that giving narcotics to put "chemical restraint on a brain cell" was almost as heinous, and that if these improved the bodily condition of a patient, they did so at the expense of the mental; by another writer he would find seclusion consigned to the same limbo as restraint; our novice would be earnestly warned to avoid degrading his mission as a physician by having anything to do with architecture, or high farming; he would be told that hygiene was a thing that anybody could understand, and he would hear from a full chorus that attendants—the agents on whom he would have to rely to carry out his orders—were a degraded class and unworthy of confidence.

It would probably occur to our suppositious Doctor that his strictly medical duties would be rather restricted, and would be limited chiefly to diagnosis, though of pathology he might have his fill; and if he had not a strong will of his own, he might not inaptly compare himself to the man with the ass in the fable, but that instead of losing his donkey he might be almost tempted to wish that he had gone over the bridge himself and down the stream in place of the quadruped.

The liability to *abuse* of any agent or system forms no adequate ground for its rejection, if its *use* can be proved to be really beneficial, and if a man has satisfied himself on sufficient evidence that restraint or seclusion, blood-letting or alcohol, narcotics, purgatives, tonics, or any other mode of treatment is beneficial to his patients, I hold that he ought to act according to his own judgment without regard to the *fashion* of treatment prevailing in his days.