

THE STRAITJACKET, THE BED, AND THE PILL

Material culture and madness

Benoît Majerus

The seat [. . .] consists of a sinkhole (a), a pot (b), discharge pipes (c) ventilation tubes (d). The whole device is covered up to the mouth of the sinkhole and the pot with wood; the pot is closed with a screwable tight lid. Sinkhole and pot are constructed like faïence tubes and have a wall thickness of 0.1'. [. . .] The inside diameter of the upper sinkhole measures 1.0', the lower only 0:27'.¹

The proliferation of asylums in the nineteenth century² resulted in an exhaustive and prescriptive literature, which went beyond discussion on the cardinal architectural principles to elaborate upon spaces for the insane. Any self-respecting psychiatrist had to take into account the materiality of these new places. If this aspect was gradually abandoned during the second half of the nineteenth century – Emile Kraepelin and George Beard, for instance, were more interested in nosological issues – the first half of the nineteenth century saw many psychiatrists, such as the likes of Joseph Guislain³ or Etienne Esquirol,⁴ debating the (future) materiality of institutions for the insane. These treatises offer easy access for anyone interested in the material culture of asylums.⁵ The excerpt quoted above is taken from this corpus. In 1869, the German physician Emil Fries published a booklet devoted to the construction of toilets in asylums. Without wishing to declare a toilet an *objet social total* that might unravel the entire history of psychiatry, the object such as imagined by Fries nevertheless allows us to address several facets of psychiatric history and to uncover the potential of a narrative that is mindful of material culture: the importance attached to drilling patients through hygiene education, a history of odours inside asylums, the difficulty in managing persons suspected of misusing even such mundane objects as toilets.

Yet, until recently, historians of psychiatry have shown only scant interest in the material culture of asylums. While the narratives are full of evocative objects – the bed, the wall, the pill – our knowledge of the material culture surrounding madness remains rudimentary, especially when it comes to overcoming the imagined materiality and focus more specifically on the practices associated with objects.⁶

Who conceived of these objects? Who created and manufactured them? Who used them in the asylum and how? Objects, similar to images in other historiographical contexts, are often only treated as having illustrative purposes and are not taken into account as a specific source. Historians have relinquished the psychiatric object to

art historians and museum curators. Art historians have been working for some years on the architectural aspects and also attach relevance to the material culture of these spaces.⁷ And as a collection of objects often defines museums, curators have attached particular importance to their materiality.⁸

Lives of objects

The purpose of this chapter is not to present a comprehensive history of all objects in psychiatry. By concentrating on the nineteenth and twentieth centuries and by limiting itself to Western Europe, it attempts to show through these three case studies not only the potential of such an analysis, but also the lacunas in current historiography. The three chosen objects – the straitjacket, the bed and the pill – offer diverse approaches and illustrate different master narratives of the historiography of psychiatry: the straitjacket represents confinement, the bed hospital culture, while the pill epitomises the so-called chemical revolution of the 1950s.

The straitjacket

In the introduction to his book on cultural material *Understanding Material Culture*, the sociologist Ian Woodward argues that ‘objects have symbolic potency because they have a place. They therefore also have a non-place: a place where they are out of context.’⁹ Undoubtedly, the straitjacket possesses an intensely potent symbolic value, because its place seems naturally within the psychiatric world – even if the narrative is more complicated today.

Along with walls and railings, the straitjacket – originally referred to as the ‘Spanish straitjacket’, by German commentators in the nineteenth century – unquestionably represents the most paradigmatic image of confinement.¹⁰ In popular culture, its mere mention suffices to evoke madness, be it in the Belgian comic *Tintin – Cigars of the Pharaoh* or in the American animated comedy *Who Framed Roger Rabbit*. In most museums dedicated to the history of medicine in general and to the history of psychiatry in particular, the story of madness is told to visitors through the straitjacket, which is presented as the natural ‘witness-object’¹¹ to speak about psychiatry.

The origins of the straitjacket are usually dated back to the second half of the eighteenth century, at a time when the Western world was broadly transforming its mode of punishment in order to humanise it (the guillotine, too, emerged from a similar impulse at the same time). If the story of the invention of the straitjacket by the upholsterer Guilleret for the Bicêtre Hospital (Paris), as narrated by, among others, Michel Foucault, has proven to be a myth similar to the story of the liberation of the insane by Pinel, ample evidence exists of its use throughout Europe in the second half of the nineteenth century.¹² Unlike ropes or chains, the straitjacket allowed the patient to walk about and was considered more humane and progressive than traditional restraints: patients could stroll about and yet not pose risks to others. In 1789, the Scottish doctor William Cullen was full of its praise:

Restraining the anger and violence of madmen is always necessary for preventing their hurting themselves or others: But this restraint is also to be considered as a remedy. [. . .] Restraint, therefore, is useful, and ought to be

complete; but it should be executed in the easiest manner possible for the patient, and the strait waistcoat answers every purpose better than any other that has yet been thought of.¹³

From the very outset the straitjacket was entangled in a history of therapeutic purpose and disciplinary function.

Frequently made of canvas, sometimes of leather, the straitjacket was initially designed to replace metal restraints. This apparent ‘softness’ explains why, at least until the middle of the nineteenth century, its use was also differentiated on the basis of gender. A French parliamentary report, for example, emphasised that the straitjacket was more often used on women than on men.¹⁴

One may assume that from the second half of the nineteenth century onwards, most asylums had straitjackets at their disposal. Given their relatively high price, it is, however, highly unlikely that the ratio proposed by the French physician Bouchardat – 10 straitjackets per 100 patients – was respected.¹⁵

As an object, it was characterised by its great heterogeneity. Typically, it was a closed jacket, equipped with buttons or strings at the back and with long sleeves whose ends are tied to the back of the wearer. Some straitjackets also covered the head, while others immobilised the legs. Over time, smaller straitjackets materialised, such as leather gloves to restrict hand movements in order to avoid scratching, or underwear designed to prevent masturbation. Some straitjackets came with a device that secured the wearer directly to his or her bed.¹⁶

Yet, the straitjacket was a disputed object virtually from its implementation. Indeed, among psychiatrists, who were concurrently starting to advocate the use of the moral treatment, its use was immediately contested. The Italian physician Vincenzo Chiarugi spoke out against it in 1794.¹⁷ Its very materiality, initially considered advantageous, swiftly became problematic. Moisture made the jacket heavy and cumbersome. Friction, due among other things to sweat, engendered skin problems and caused abrasions. Immobilising the hands caused hygiene complications: patients could neither blow their noses nor go to the toilet alone. Such criticism, particularly articulated by those involved in the non-restraint movement in England, provoked staunch responses from French and German psychiatrists who defended its use. Yet even in France, opinion changed rapidly. In 1871, Eugene Rouhier wrote in his dissertation at the Medicine Faculty in Paris, ‘The straitjacket has introduced real progress, because it caused iron chains, rings attached to the walls, etc. to little by little disappear from asylums.’¹⁸ However, thirty years later, in a similar exercise, Girard concluded that the ‘mechanical containment [straitjacket] in asylums is the shame of the twentieth century; it must be banished’.¹⁹ By the end of the nineteenth century, the straitjacket had already turned into the motif for a dehumanising psychiatry. In travel reports by psychiatrists published at that time, the unrestrained use of the straitjacket became the symbol of an antiquated system of care.²⁰ And in the first anti-psychiatric wave of the second half of the nineteenth century, denouncing the straitjacket was to become a recurring leitmotif.²¹

As for its use, in the absence of historical literature on the matter, we can only make assumptions. The decision to deploy a straitjacket belonged mainly to the caretakers and keepers despite numerous recommendations, including those from Pinel, that its use should only be practised under a physician’s direct supervision.²² It is evident that

it was handled by hospital staff and nurses without any involvement by psychiatrists. Putting a patient into a straitjacket required specific know-how and training in order to force the patient into the garment; the action was not without risk to the immobilised person's breathing:

The best procedure consists of oneself moving both arms backwards into the straitjacket, and in this way to go through the opening in the shoulders in front of the patient's hands; then lead the patient into the straitjacket by leading him through the same path, while an assistant standing behind the patient, draws the body of the straitjacket towards himself and then laces it at the back, taking care not to tighten the neck nor to compress the chest so as not to interfere with the [patient's] breathing.²³

This vivid description reveals little of the actual violence involved in putting someone into a straitjacket. While wearing the straitjacket in itself was a source of multiple injuries, putting someone into the straitjacket was an extremely violent moment during which numerous fractures could and did occur.²⁴ Psychiatric textbooks and

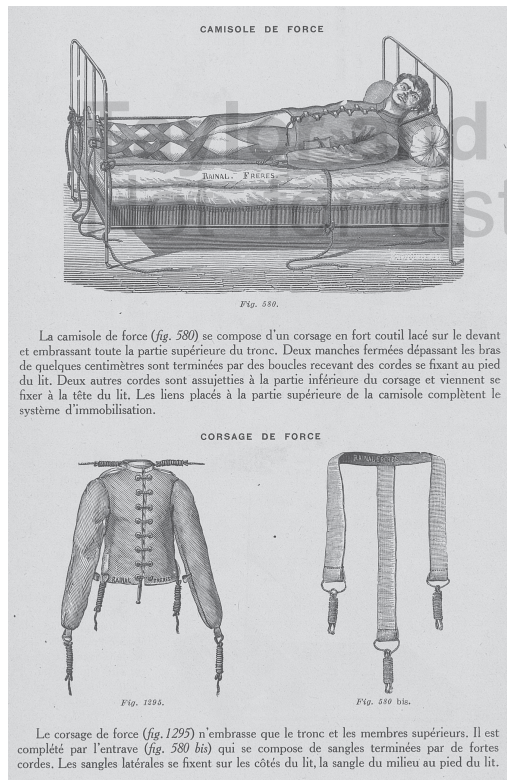


Figure 14.1 The straitjacket and its accessories. Extract from the Rainal Brothers' catalogue, suppliers of the military and civilian hospitals and the Faculty of Medicine in Paris.²⁵

historians' written accounts, however, remain largely silent on practices – duration of confinement, patient's personal experiences, therapeutic goals – involving the straitjacket.

The object gradually disappeared from psychiatric textbooks over the course of the twentieth century.²⁶ In a profession that longed to be 'modern' and that relied on its first biological therapies (insulin shock, Cardiazol [PZT], etc.), the straitjacket became a proscribed object, at least in academic discourse. In his illustrious handbook on psychiatry, Emmanuel Régis used the word 'straitjacket' some twenty times in the first edition of 1885, but not at all in the sixth and final one in 1923.²⁷ Within the asylum, however, it did not disappear as quickly from practice. Again, in the absence of detailed studies, it is difficult to propose an exact chronology of its use. It would appear that since the 1960s, its usage has decreased. Nevertheless, in many psychiatric hospitals, the object remains on hand nowadays for particularly agitated patients, even if the object's materiality has changed fundamentally in order that it appears less enveloping. The Canadian company Segufix dominates today's market, priding itself on having invented 'human immobilisation'.²⁸

Besides a bed for agitated patients (see below), the straitjacket was for a protracted period the only psychiatric object to be found in general medical catalogues. While other medical disciplines such as surgery, gastroenterology, ophthalmology, dermatology, and gynaecology were characterised by an ever-growing arsenal of instruments, psychiatry lagged relatively far behind in this respect.

Even if the straitjacket appears as the psychiatric object *par excellence*, its use nonetheless rapidly extended beyond the asylum's walls – and not only figuratively speaking.²⁹ It was already being used from the nineteenth century onwards on the outside; for example, by families who had custody of insane dependants.

Moreover, it was a commonplace device in general hospitals for patients with diseases that caused agitation such as smallpox; in prisons and institutions for children and difficult teenagers (hence its application was similar to that in psychiatry) from the nineteenth century on;³⁰ as well as in the entertainment world (escape artists and contortionists); and it remains an aid in sexual practises to this very day.

The bed

During the eighteenth century, the bed had become a central feature of the hospital, and to this day 'the hospital comprises hundreds of beds'.³¹ In the second half of the nineteenth century, psychiatrists, in their efforts to integrate the medical field, organised wards around beds. The bed also served as the standard quantitative unit in hospitals. Thus, when discussing the capacity of asylums, policy makers and physicians spoke of 'x number of beds' and not 'x number of patients'. A bed needed a certain amount of cubic meters and had a 'daily price' and an 'annual price' that facilitated cost comparisons for various services and the calculation of over- and under-population. The psychiatric upheaval of the 1960s mobilised under the slogan of the 'reduction of psychiatric beds'. Moreover, the bed was an object that had to be adapted to the internal uses and needs of insane asylums. A peculiar material grammar emerges, but it was seldomly made explicit.

In the early nineteenth century, beds were made of wood, while mattresses were often filled with straw that required regular replacement. Many asylums had their

own carpentry units where beds were built, while those facilities in the countryside also furnished their own straw. During the first half of the nineteenth century, medical institutions replaced their wooden beds with lacquered iron bedsteads, which, while certainly being more expensive, were considered more hygienic and less prone to infestation by vermin. Constructing these beds was no longer possible inside the asylum, but remained operative at a local or regional level and were not specific to individual asylums, even if some manufacturers specialised in what Erving Goffman termed ‘total institutions’. (The Bouvier Company in Lyon, for instance, offered ‘production of iron beds and patented mesh bases. Specialised items for colleges, seminaries, communities, asylums, orphanages, factories, etc.’)³² The hospital in general, and the asylum in particular, became an attractive market, and the burgeoning medical press of the nineteenth century partially lived off advertising revenues from these objects. Most hospital furniture manufacturers offered – besides the conventional hospital bed – a bed for agitated and/or senile patients equipped with bars making it difficult to get out of; they also proposed a solution to dispose of excrement without the patient having to leave the bed to go to the toilet.

In contrast to general hospital wards, where screens often separated beds in large dormitories, beds in psychiatric units remained visible to the scrutiny of psychiatrists, staff-members, nurses, as well as other patients.

Prior to the 1960s, patients were routinely put to bed upon being admitted. This procedure served several functions. The bed was primarily a symbol of the general hospital: a person confined to bed during the day was associated with being sick. The bed became a symbol for disease. Its use inside an asylum, therefore, meant that insanity should likewise be considered a disease. Confining someone to bed was a technique designed to discipline not only the body, but also the ward activity. The spatial organisation of each ward was dictated by the bed arrangement, an arrangement that was supposed to indicate order and cleanliness. This was true for medicine in general – just look at the numerous photos of medical services in which one sees beds carefully lined up – but even more so in psychiatry, where the bed was the crucial tool for controlling the patient. In their widely read textbook of psychiatry, Mignot and Marchand emphasised that:

Beds should be wide enough apart so that patients cannot reach the neighbouring bed by hand and they must be at a distance from the walls; it is necessary that nurses can do their rounds effortlessly so as to take care of those agitated in their moments of excitement.³⁴

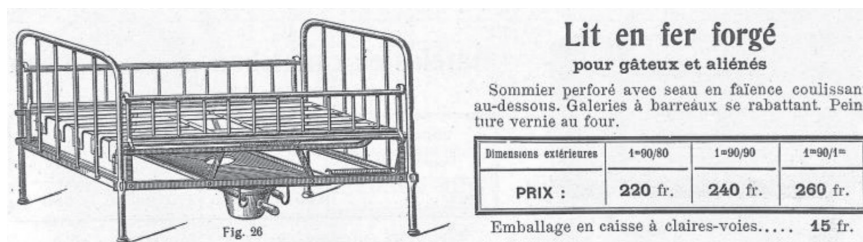


Figure 14.2 Bed for senile and mentally ill patients³³

The bed was also a potent indicator of social distinctions within the asylum system. Psychiatric spaces – asylums in the nineteenth century as well as psychiatric wards inside a general hospital in the early twenty-first century – remained places where class issues were deeply significant. In 1831, the German psychiatrist Christian Friedrich Wilhelm Roller proposed different categories of wood for different classes of patients.³⁵ Fifty years later, in 1885, the regulations in Stephansfeld, an asylum near Strasbourg, stipulated that patients from the first, second, and third classes were entitled to six bed sheets, while those from the fourth and fifth classes merely four.³⁶ Finally, there were also important distinctions between the standard hospital bed that structured the space in large dormitories and the bed of the wealthy bourgeois asylum. Such asylums strove to differentiate their space as much as possible from a standard asylum by replicating a typically bourgeois interior by means of a different material culture. John Perceval, a patient in Ticehurst – ‘psychiatry for the rich’ – made a list of the contents of his two-roomed apartment: ‘the walls papered, the floor carpeted, a sofa in it, a small bookcase, mahogany table and chairs, a marble chimney-piece, a large sash-window; a cheerful fire in the grate.’³⁷

The psychiatric bed was mostly a modified hospital bed. At the Institute of Psychiatry in Brussels,³⁸ the bed, built of iron with rounded corners, contained numerous details that revealed its psychiatric specificity. Admittedly, the beds were not fixed to the ground, as advocated in many psychiatric manuals, in order to ensure some flexibility in case of overcrowding, and to facilitate cleaning the floors. To ensure stability, the architect constructed beds ‘with round wooden legs instead of casters.’ Furthermore, and in contrast to beds in other medical departments inside the same hospital, those at the Institute of Psychiatry did not have bars at the head and foot of the bed, but instead full panels so as to prevent any suicide attempts were the patient to attach sheets to the bars. Psychiatric beds were not equipped with a small light as in other wards, in order to avoid burns, cuts, and electrocution. Until the 1950s, the bed was the place where medical records were written up and hence where a person was transformed into a ‘patient.’³⁹ These records, however, were not attached to the patient’s bed as in other medical departments. In psychiatry, they were often kept in the nurses’ station.

For many psychiatrists, the bed had a therapeutic value. It was thought that resting the elongated human body was conducive to relaxing the nervous system.⁴⁰ The excitement aroused by modern urban life, *inter alia*, was considered one of the primary factors in the apparent increasing number of alienated. From the nurses’ and attendants’ perspective, to accept being put to bed during daylight hours was an indicator of the degree of the newcomer’s obedience. This was often the moment the patient was initially confronted with the practical constraints of institutional life. Yet reforms and (apparent) therapeutic ruptures affecting psychiatry in the 1950s and 1960s also transformed the bed’s role. Henceforth the psychiatric hospital began promoting the reintegration of patients into society as one of its primary functions, and it tried to simulate life and work conditions in the outside world. Lying in bed all day was no longer desirable. Admittedly, beds continued to organise the available space on the wards, but the nursing and medical staff no longer systematically forced patients to stay in bed for protracted periods. Resting in bed – an ‘activity’ considered as unproblematic during the interwar period – was to become a worrisome symptom from the 1960s onwards, as activities such as occupational therapy entered the asylum.

It was only at that juncture that another reality became apparent in doctors' and nurses' notes: the bed as the primary private space available to the recluse. The bed was often the only space that was specifically devoted to the individual. Unquestionably, all beds were alike and it was strictly forbidden to customise them, at least until the 1950s. Each patient was nonetheless given a specific bed upon being admitted to a ward, and they rarely switched beds during their stay, which at times could even last several months. The patient could withdraw to their beds where they had sheets under which to 'hide'. Curiously, it was through the resistance of those who did not want to quit their beds, despite the therapeutic changes introduced in the 1960s, that this appropriation of the bed became visible to historians.

The pill

The pill often only first appears in historical narratives of psychiatry with the discovery of neuroleptics in the 1950s. Yet it was a commonplace object inside many asylums at the latest from the latter half of the nineteenth century.⁴¹ For many psychiatrists, these medications decisively excluded continued use of an item discussed above, namely, the straitjacket. Already in 1894, Paul Lefert wrote, 'Since 1873, I have always used this medication, with or without morphine, and success has been consistent each time patients have been spared the straitjacket.'⁴²

If some authors deemed that a pharmacy was not really necessary inside an asylum,⁴³ others like Scipio Pinel in his manual on building institutions for the insane stressed its significance. 'The pharmacy,' he stated, 'is, after the kitchen, the most important room within a hospital.'⁴⁴ And when in 1862 the French psychiatrist Pierre Berthier published his travel notes on French asylums, he noted that several institutions had a room specifically set aside for drugs.⁴⁵ Yet, the object did not only determine the space, but also the professions working within the institution, as the position of the pharmacist became more common within asylums.⁴⁶

If the straitjacket and the bed were both based on artisanal know-how, the pill was inscribed in other frameworks from the early nineteenth century on. Initially, drugs were fabricated in the pharmacy in diverse forms: pill, injection, medicinal-syrup.⁴⁷ Given that psychiatric patients proved especially reluctant to take drugs, psychiatrists began experimenting from the nineteenth century onwards with making medication more palatable. Thus paraldehyde, a sedative used in psychiatry since the 1880s, was administered with rum or lemon to camouflage its unpleasant taste,⁴⁸ but it did not succeed in removing the disagreeable odour characterising psychiatric wards till the 1950s when the use of paraldehyde fell into decline.⁴⁹

From the second half of the nineteenth century, drugs were increasingly manufactured outside the asylums. Initially, they were handmade, but their production became increasingly industrial by the end of the nineteenth century. They were no longer produced by regional manufacturers who often worked in cooperation with renowned physicians, but instead by pharmaceutical companies operating at a national or international level and mobilising chemical knowledge that no longer had any direct link with psychiatry. Despite the fact that the drugs are often considered to have integrated psychiatry into the capitalistic system from the 1960s onwards, advertisement for medical drugs of all sorts were already filling pages of psychiatric journals in the late nineteenth century, thus ensuring continual funding.

Drug distribution also entailed the construction of a specific piece of furniture. In 1836, Scipion Pinel recommended making small boxes, a 'square containing drugs, with a number on it corresponding to the bed number'.⁵⁰ These pillboxes were present in non-psychiatric settings from the early nineteenth century on and experienced a new relevance with the release of psychiatric drugs outside asylums walls in the second half of the twentieth century. Psychiatric therapy became increasingly mobile with the consumption of pills and found its place in life beyond the walls.

Moreover, the issue of compliance in psychiatry arose at the same point as a new contingency. Although some of these substances came in liquid form that was to be injected, most antipsychotics were taken in tablet form. Due to their materiality, however, the administration of pills required some cooperation on the part of the patients. Compared with other prevalent psychiatric therapies, such as ECT, taking medication was an act that paradoxically served to weaken the medical grip. Not only did its materiality afford the patients some command over compliance or non-compliance, but it also enabled therapy outside the hospital walls.

To solve the problem of medical compliance outside an institutionalised setting, the pharmaceutical industry developed from the mid 1960s the so-called long-acting (depot) neuroleptics. Based on a similar process to that invented years earlier for insulin, the patient received a slow-release depot injection with a drug that would be effective not just for several hours, but for several weeks (usually one month). This transformative change in the function of medical drugs spread increasingly after the 1970s and was considered by certain researchers as the basis for a sustainable development of social psychiatry.⁵¹ This produced paradoxical effects. While ex-patients could treat themselves at a remove from medical scrutiny, this innovative procedure nonetheless enabled psychiatrists to strengthen their grip on formerly institutionalised patients now outside the walls of the asylum.

While the question of whether a rupture was introduced by neuroleptics continues to occupy historians,⁵² drugs in tablet form admittedly led to changes on many levels. Within a decade, pills achieved a therapeutic domination that no other form of treatment had hitherto accomplished. Considering neuroleptics through their chemical materiality induced a break in the design of pathological forms of the psychic. By analysing how Chlorpromazine (CPZ) – the first antipsychotic medication – worked, the dopamine hypothesis was developed. The neuroleptic blocks D2 dopamine receptors, and its antipsychotic effect was attributed by researchers to this blocking action. Consequently, a surplus of dopamine was considered responsible for fostering symptoms of schizophrenia.⁵³

Of the three commonplace medical objects presented in this essay, the pill is undoubtedly the one that has been the most anthropomorphised. That it had its own agency was rarely contested. Many drugs had emotionally evocative names, and in popular culture, songs about particular neuroleptics are numerous: probably the best known are 'Purple Hearts', the name given to Drinamyl, a popular stimulant made from dexamphetamine and barbiturates, and 'Mother's Little Helper', the nickname given to Valium by the Rolling Stones.⁵⁴

The consumption of neuroleptics also became a highly visible marker of differences in class, gender, and age. Consumption within the asylum remained strongly determined by non-negotiated prescriptions from the physician. Outside of the

hospital, psychiatric medication became a distinguishing element just like other consumer goods. Thus Miltown (Mepromate) was first found in the mouths of Hollywood stars before becoming a mass-consumed commodity. If no antipsychotic attained the iconic character of the blue diamond of Viagra, the trade dress (i.e. the visual appearance of the drug and its packaging) played a key role.⁵⁵

Psychiatric drugs also profoundly changed the relationship between patient and psychiatrist. Drug therapy – unlike nineteenth-century therapies such as the straitjacket – was no longer a measure always prescribed by the doctor, but was sometimes requested by the patients themselves. While initial attempts at biological therapies in the interwar period had already given rise to requests by patients, these were rare in psychiatry, owing to the fact that the side-effects of treatments like insulin and ECT were relatively disagreeable. Psychotropic drugs transformed that situation. In psychiatric hospitals, patients regularly demanded pills.⁵⁶ Some historians argue that outside of psychiatric institutions, demand was essentially driven by patients and ex-patients.⁵⁷ Drugs introduced, at least partially, ‘consumer sovereignty within psychiatry’. The flagship of material cultural studies, the history of consumption, shatters the history of psychiatry focused exclusively on confinement. Psychiatric drugs deinstitutionalised the history of psychiatry and illustrates the ubiquitous presence of psychiatry in everyday life in Western society. Yet, they escaped not only from the asylum, but also from the grip of psychiatrists as well. In 1975 in the United States, 75 percent of minor tranquilizers were prescribed by general practitioners and only 25 percent by psychiatrists.⁵⁸

If the first two objects examined clearly determined the psychiatric identities of their users – a person bound in a straitjacket was ‘crazy’ and the one lying in bed was sick – the pill thanks to its ubiquitous use did not perform a similarly total identification. Unlike the effects produced by the two other objects, a person taking psychiatric medication was not reduced to a psychiatric identity. Of the three objects selected to illustrate a material history of psychiatry, it is indisputably the last one for which the critical theory inspired by the Marxist idea of material culture was most often used: a pill as a commodity, as a product of capitalist society with a strong capacity to alienate.

The trajectory of objects

Studying material culture enables access to the history of people living and working inside the walls of an insane asylum. One could multiply the examples here, but I hope that this chapter provides sufficient material to open up four potentially fertile research fields.

The first and most obvious one is the interdependence between objects, which determine daily psychiatric practice and the psychiatry that transforms those objects. Thus, the bed changes its function when transposed from a standard room to an asylum. On a symbolic level, the bed that provides rest is transformed into a tool for classification and confinement. On a material level, this change results in slight, but significant modifications. And the bed structures psychiatric space, as it organises the layout of the hospital interior.

Second, the daily experience of psychiatry for doctors, nurses, and inmates has rarely been studied through the prism of its material culture. The history of asylums has for a long time been dominated by the history of psychiatrists. Over the last fifteen

years, the voice of the inmate has become more audible, yet one set of actors remains largely unknown: nurses. This third party was particularly key in the daily running of the institution and in determining the use of many objects. When examining workbooks, diaries, and memoirs, the materiality of these objects is always central in the writing of the attending nurses.

Third, when evaluating these objects in terms of their 'biography', one overcomes a static description and instead one sees how they often led a triple life. At first, they are conceived objects. In the case of the aforementioned bed at the Institute of Psychiatry, there was an engineer-architect and a psychiatrist, with manifold frames of references. The architect had already participated in the construction of several hospitals, and from the late 1920s the two men were visiting other asylums in Belgium and abroad as well as prisons. At that time, an asylum was still conceived as a confined space, a space in which to literally confine. Gradually, however, the anti-psychiatric wave that had been shaking Europe and northern America since the late nineteenth century left its mark on both movable and immovable objects that populated the asylums. The negative effects giving the impression of confinement were taken into account. This impulse expressed itself in the creation of a feeling of an architectural opening up: the garden fence disappeared behind the hedges or the steel window frame hidden behind a veneer. In a second step, these imaginary objects had to be transformed into lifelike objects. This transformation confronted numerous obstacles, such as technical impossibilities or manufacturing faults. Yet, discussions between architects, contractors, and psychiatrists were ultimately productive because they also involved new areas of experience. The craftsman, in response to specifications, often proposed alternative solutions which neither the engineer nor the psychiatrist had envisaged. It was only during a third stage that these objects became 'acted objects', objects that are incorporated by actors. Each of these lives and their interactions demand our attention. What is particularly interesting is the gap that may exist between the object as initially conceived and the 'acted object'. Particularly given that besides the function of the 'acted object', the straitjacket, the bed, and the pill also become 'acting objects' that ultimately shape and transform psychiatric space, practice, and experience. Based on the material culture of the asylums, the Australian historian Catherine Coleborne speaks of the psychiatric hospital as a 'myth' because it has only rarely been as people imagined it.⁵⁹ In exploring the three lives of objects and their interactions, we can try to alter this discrepancy to which researchers in the social sciences may equally fall victim to as 'ordinary people'. Material culture shows the heterogeneity of possible fields of action for all the actors in the history of psychiatry.

On a final note, scholarly interest in the material culture of the object always interrogated the means of production, a process that took place mainly on the hospital grounds during the nineteenth century, but went on elsewhere over the course of the twentieth century. Marketing was also another source of interest. Conceiving of and producing a straitjacket, a bed, or a psychiatric drug was increasingly undertaken outside of the psychiatric space during the twentieth century. The history of psychiatry must exit the institution – and that well before the deinstitutionalisation of the 1960s⁶⁰ – to write an economic history of psychiatry: a history of material culture which draws attention to the story of the marketplace and marketing of these psychiatric objects.

Notes

- 1 ‘Der Sitz (. . .) besteht aus dem Trichter (a), dem Topfe (b), dem Abführrohre (c) und dem Ventilationsrohre (d). Die ganze Vorrichtung ist bis auf die Mündungen von Trichter und Topf mit Holz verkleidet, der Topf durch einen dichten anliegenden Deckel verschlossen, der abgeschraubt werden kann. Trichter und Topf sind wie die Röhrenleitung von Steingut angefertigt, haben eine Wandstärke von 0.1’. (. . .) Die lichte Weite der oberen Trichtermündung beträgt 1,0’, die der unteren nur 0.27’.’ Emil Fries, *Das Latrinen-System der Kreis-Irrenanstalt Werneck* (Würzburg, A. Stuber, 1869), 8.
- 2 Cf. Andrew Scull’s chapter in this volume.
- 3 Joseph Guislain, *Traité sur l’aliénation mentale et sur les hospices des aliénés* (Amsterdam: Van der Hey, 1826).
- 4 Etienne Esquirol, *Des établissements des aliénés en France et de moyens d’améliorer le sort de ces infortunés* (Paris: Huzard, 1819).
- 5 Given the significant digitalisation of nineteenth-century books, most of this literature is now accessible on the web. The school, another place of standardisation, was also a topic of intense discussion. These two institutions were sometimes addressed in a single book: Félix Narjoux, *Les écoles publiques en France et en Angleterre: construction et installation, documents officiels, services extérieurs, services intérieurs, salles d’asile, mobilier scolaire, services annexes* (Paris: Morel, 1877).
- 6 Jennifer L. Bazar’s recent dissertation offers a powerful case advocating integrating the history of material culture into the historiography of psychiatry. Jennifer L. Bazar, *Objects of Daily Life: Materiality in North American Institutions for the Insane* (Ph.D. Diss., York University, 2013).
- 7 Leslie Topp, James E. Moran, and Jonathan Andrews, eds, *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (London: Routledge, 2007).
- 8 Catharine Coleborne and Dolly MacKinnon, *Exhibiting Madness in Museums: Remembering Psychiatry through Collections and Display* (New York: Routledge, 2011) and also the excellent blog ‘Bethlem Museum of the Mind’. (<http://museumofthemind.org.uk>) that contains a section ‘Object Lesson’.
- 9 Ian Woodward, *Understanding Material Culture* (Los Angeles: Sage, 2007), 66.
- 10 Will Wiles, ‘Straitjacket: A Confined History’ in *Insanity and the Lunatic Asylum in the Nineteenth Century*, ed. Thomas Knowles and Serena Trowbridge (London: Pickering & Chatto, 2014), 167–181.
- 11 Marie-Pierre Julien and Céline Rosselin, *La culture matérielle* (Paris: La Découverte, 2005), 34.
- 12 Wiles, “Straitjacket: A Confined History,” *op. cit.*
- 13 William Cullen, *First Lines of the Practice of Physic, Vol. 4* (Edinburgh: C. Elliot, 1789), 151–155; Wiles, “Straitjacket: A Confined History,” *op. cit.*, 172.
- 14 France Commission d’enquête parlementaire sur le régime des établissements Pénitentiaires, *Enquête parlementaire sur le régime des établissements pénitentiaires* (Paris: Cerf et fils, 1873), 41.
- 15 A. Bouchardat, “Mémoire sur l’hygiène des hôpitaux et hospices civils de Paris,” *Annales d’hygiène publique et de médecine légale*, 17 (1837): 37–73, 71.
- 16 The manufacture of the straitjacket could not be elucidated in detail. In *La Lancette française, gazette des hôpitaux civils et militaires*, Dr. Nicole regularly published between 1837 and 1843 advertisements for iron beds, crutches and straitjackets. At the end of the nineteenth century, several patents were filed in relation to ‘insane costumes’, particularly by the Matray, Schmittbuhl & Company, suggesting that a craft around this product existed. The Drapier House in Paris, specialising in the manufacture of bandages and belts, featured a straitjacket in its catalogue in the early twentieth century: *Catalogue de la maison Drapier: bandages herniaires, ceintures – bas pour varices, accessoires* (Paris: Drapier et Fils, 1911).
- 17 Ian Robert Dowbiggin, *The Quest for Mental Health; A Tale of Science, Medicine, Scandal, Sorrow, and Mass Society* (New York: Cambridge University Press, 2011), 40.
- 18 “La camisole fut un progrès réel, car elle fit disparaître peu à peu des asiles, les chaînes en fer, les anneaux fixés aux murs, etc.” Eugène Rouhier, *De la camisole ou gilet de force* (Université de Paris, Faculté de médecine, 1871) 11.

- 19 “La contrainte mécanique dans les asiles d’aliénés est la honte du XXe siècle; il faut qu’elle disparaisse.” P. Girard, *De la suppression de la camisole de force dans les asiles d’aliénés* (Impr. G. Firmin, Montane et Sicardi, 1904), 32.
- 20 Rudolf Arndt, *Lehrbuch der Psychiatrie für Ärzte und Studierende* (Vienna: Urban & Schwarzenberg, 1883), 325.
- 21 Aude Fauvel, ‘La voix des fous. Hector Malot et les “romans d’asile,”’ *Romantisme*, n° 3 (2008): 51–64.
- 22 See, for example, Sophie Richelle, *Les ‘folles’ de Bailleul. Expériences et conditions d’internement dans un asile français (1880–1914)* (Brussels: Université des femmes, 2014), 110–111.
- 23 Le meilleur procédé consiste à passer soi-même les deux bras au rebours dans les manche de la camisole, et d’aller ainsi, par l’ouverture des épaules, au devant des mains du malade, qu’on entraîne dans les siennes en sortant par la même voie, pendant qu’un aide, placé derrière le malade, tire à soir le corps de la camisole qu’il lui lace sur le dos, en ayant soin de ne pas serrer le cou ni de comprimer le thorax au point de gêner la respiration. Emmanuel Régis, *Manuel pratique de médecine mentale*, 1^{re} éd. (Paris: Octave Doin, 1885), 486. In numerous nursing textbooks, there was a detailed description of how to set the straitjacket.
- 24 E. Rouhier, *De la camisole ou gilet de force*, *op. cit.*
- 25 Rainal Frères, *Catalogue général* (Paris: Maréchal, 1925), 313. In the Rainal Brothers catalogue of 1934, the straitjacket no longer features.
- 26 In the Drapier catalogue (1929), the straitjacket is available in 1911, but no longer features in 1929.
- 27 Emmanuel Régis, *Manuel pratique de médecine mentale*, 1^{re} éd. (Paris: Octave Doin, 1885) and *Précis de psychiatrie*, 6^e éd. (Paris: Octave Doin, 1923).
- 28 www.segufix.com, accessed 2 April 2015.
- 29 From the nineteenth century onwards, the term *camisole de force* is used to figuratively express ‘ce qui contraint’ [that which constrains]: www.cnrtl.fr/definition/camisole, accessed 2 April 2015.
- 30 In Belgium, the female minor inmates at the *asile-clinique* in Bruges even manufactured straitjackets for other similar institutions. See Veerle Massin, *Protéger ou exclure? L’enfermement des ‘filles perdues’ de la Protection de l’enfance à Bruges (1922–1965)* (Thèse de doctorat, Université catholique de Louvain, 2011), 328.
- 31 Jean-François Laé, “Le lit, dispositif de l’institution totale” in *L’asile aux fous. Photographies de Roger Camar*, ed. Philippe Artières and Jean-François Laé, (Paris: Presses Universitaires de Vincennes, 2009), 99–117.
- 32 *Annuaire de l’Union fraternelle du commerce et de l’industrie* (Paris, 1892), 187.
- 33 Vve Dupont and André Dupont, *Lits, fauteuils, voitures et appareils mécaniques pour malades et blessés* (Paris: Farcy, 1914), 13.
- 34 ‘Les lits doivent être très écartés les uns des autres afin que les malades ne puissent atteindre avec la main les sujets des lits voisins; ils doivent être éloignés des murs; il faut que les infirmiers puissent en faire facilement le tour pour maintenir les agités dans les moments d’excitation.’ Roger Mignot and Ludovic Marchand, *Manuel technique de l’infirmier des établissements d’aliénés* (Paris: Gaston Doin, 1931), 307.
- 35 Christian Friedrich Wilhelm Roller, *Die Irrenanstalt nach allen ihren Beziehungen* (Karlsruhe: Chr. Fr. Müller’schen Hofbuchhandlung, 1831), 133.
- 36 Asile de Stéphansfeld, ‘Maison de Santé pour le traitement des malades mentales – Renseignements pour les familles.’
- 37 Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792–1917* (London, Routledge, 1992), 70.
- 38 This paragraph is based on Benoît Majerus, ‘La baignoire, le lit et la porte. La vie sociale des objets de la psychiatrie,’ *Genèses*, 82 (2011): 95–119.
- 39 Karen Nolte, ‘Vom Verschwinden der Laienperspektive aus der Krankengeschichte: Medizinische Fallberichte im 19. Jahrhundert’ in *Zum Fall machen, zum Fall werden. Wissensproduktion und Patientenerfahrung in Medizin und Psychiatrie des 19. und 20. Jahrhunderts*, ed. Sibylle Brändli, Barbara Lüthi and Gregor Spuhler (Frankfurt a. M.: Campus, 2009), 33–61, 35.

- 40 S. Weir Mitchell proposed a particularly extreme form of rest cure whereby patients should stay in bed for up to six weeks without being allowed to sit, read, or even get up to go to the toilet. See S. Poirier, 'The Weir Mitchell Rest Cure: Doctor and Patients', *Women's Studies: An Interdisciplinary Journal*, 10 (1983): 15–40.
- 41 See Toine Pieters's chapter in this book as well as Sara Black's forthcoming dissertation entitled 'Psychotropic Society: The Medical and Cultural History of Drugs in France, 1840–1920.'
- 42 'Depuis 1873, j'ai toujours eu recours à ce médicament, avec ou sans morphine, et le succès a été constant, toutes les fois que les malades ont été préservés de la camisole de force.' Paul Lefert, *Manuel du médecin praticien. La pratique des maladies du système nerveux dans les hôpitaux de Paris, etc.* (Paris: Baillière, 1894), 13.
- 43 See, for example, Roller, *Die Irrenanstalt nach allen ihren Beziehungen*, *op. cit.*
- 44 'La pharmacie est, après la cuisine, la pièce la plus importante de l'hôpital.' Scipion Pinel, *Traité complet du régime sanitaire des aliénés, ou Manuel des établissements qui leur sont consacrés* (Paris: Mauprivez, 1836), 37.
- 45 Pierre Berthier, *Excursions scientifiques dans les asiles d'aliénés* (Paris: Bourg-en-Bressir, 1862).
- 46 See, for example, a job advertisement for two pharmacists, published by the public asylums of the Seine Department in 1904. 'Chronique', *L'Union pharmaceutique: journal de la Pharmacie centrale de France: organe des intérêts scientifiques, pratiques et moraux de la profession* (1904), 592.
- 47 At the museum of Sainte-Anne (Paris), several devices have been preserved showing how such local production took place.
- 48 'Editorial', *The Alienist and Neurologist*, 5 (1884), 547–560, 554.
- 49 E. M. Tansey and D. A. Christie, "Drugs in Psychiatric Practice" in *Wellcome Witnesses in Twentieth-Century Medicine*, ed. E. M. Tansey and D. A. Christie (London: Wellcome Trust Centre for the History of Medicine at UCL, 1997), 131–205, 157.
- 50 S. PINEL PINEL, *Traité complet du régime sanitaire des aliénés, ou Manuel des établissements qui leur sont consacrés.*, *op. cit.*, p. 37.
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- 52 N. Henckes, '(Magic) Bullet in the Head? Psychiatric Revolutions and their Aftermath' in *The End of the Therapeutic Revolution?*, ed. J. Greene, F. Condrau, and E. S. Watkins (Chicago: University of Chicago Press, forthcoming).
- 53 Alan A. Baumeister and Jennifer L. Francis, 'Historical Development of the Dopamine Hypothesis of Schizophrenia', *Journal of the History of Neurosciences*, 11 (2002): 265–277.
- 54 Andrea Tone, *The Age of Anxiety: A History of America's Turbulent Affair with Tranquilizers* (New York: Basic Books, 2009), IX.
- 55 Jeremy Greene and Aaron S. Kesselheim, 'Why Do the Same Drugs Look Different. Pills, Trade Dress and Public Health,' *The New England Journal of Medicine*, 365 (2011): 83–89.
- 56 Benoît Majerus, 'Making Sense of the "Chemical Revolution". Patients' Voices on the Introduction of Neuroleptics in the 1950s,' *Medical History*, 60 (2016): 54–66.
- 57 Tone, *The Age of Anxiety*, *op. cit.*, p. 95.
- 58 Andrea Tone, 'Tranquilizers on Trial: Psychopharmacology in the Age of Anxiety' in *Medicating Modern America: Prescription Drugs in History*, ed. Andrea Tone and Elizabeth Siegel Watkins (New York: New York University Press, 2007), 156–182, p. 164.
- 59 Catharine Coleborne, "'Madness': Material Culture and the Asylum', *Health and History*, 3 (2001): 104–117, 99.
- 60 Greg Eghigian, 'Deinstitutionalizing the History of Contemporary Psychiatry', *History of Psychiatry*, 22 (2011): 201–214.