

# Material Objects in Twentieth Century History of Psychiatry<sup>1</sup>

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Interest in the history of psychiatry in the social sciences manifested itself in the sixties and seventies at a moment when concepts such as marginality and deviance appeared as a thought-provoking path to rewrite the history of Western societies. This history of madness faces a turning point. Material culture, as this paper's line of argument expounds, allows one to remain faithful to the critical heritage of the sixties and seventies while still opening up the field to alternative questions by integrating new actors and themes hitherto largely ignored. It allows nuanced narratives that take into account the structural imbalances of power while at the same time being attentive to the agencies of all the actors, as well as the failures of the institutional utopias.

*Materiële objecten in de twintigste eeuwse geschiedenis van psychiatrie*

De belangstelling voor de geschiedenis van de psychiatrie in de sociale wetenschappen manifesteerde zich in de jaren zestig en zeventig op een moment dat begrippen als marginaliteit en afwijkend gedrag veelvuldig werden gebruikt om de geschiedenis van de westerse samenlevingen te herschrijven. De geschiedschrijving over krankzinnigheid staat nu op een keerpunt. Door het bestuderen van materiële cultuur, zoals in dit artikel wordt betoogd, maakt het mogelijk om de erfenis van de jaren zestig en zeventig te behouden, maar tegelijkertijd het vakgebied te confronteren met alternatieve vragen door actoren en thema's te integreren die tot nu toe grotendeels buiten beschouwing gebleven zijn. Dit maakt het mogelijk een genuanceerd betoog te schrijven, daarbij rekening houdend met structurele machtsverschillen, recht te doen aan de verschillende actoren, en tegelijkertijd het falen van de institutionele utopia's in ogeschouw te nemen.

Interest in the history of psychiatry in the social sciences manifested itself in the sixties and seventies, at a moment when concepts such as marginality and deviance appeared as a thought-provoking path to rewrite the history of Western societies. This political history of madness, which gradually integrated questions of social history, has furnished a successful master narrative for the historiography of psychiatry for more than three decades. Today however, this historiography faces a turning point. How can it renew its approaches? How can it integrate the history of the twentieth century into accounts still profoundly influenced by nineteenth century narratives such as professionalisation, confinement or medicalisation?<sup>2</sup> And, how can this specialised field incorporate broader historiographical discussions? Material culture, as this paper's line of argument expounds, allows one to remain faithful to the critical heritage of the sixties and seventies while yet opening up the field to alternative questions by integrating new actors and themes hitherto largely ignored.<sup>3</sup>

The material turn forms part of a larger set of turns that has impacted upon the humanities since the seventies. Inspired by archaeology, art history, literary studies and anthropology, the attractiveness of this particular shift is probably linked to the fact that goes beyond (Marxist) structuralism of the seventies without being reduced to pure culturalism that threatened the humanities since the beginning of the twenty-first century. The apparent stability and anchored physicality of objects, and at the same time their permanent symbolic redefinition, assigns them a seismographic function for historians interested in how everyday life inscribes domination into bodies through materiality, but also how the agency of the actors can instil new – and unintended – biographies into objects.<sup>4</sup>

1 I would like to thank the participants of the workshop organised by the editors of this volume, the anonymous reviewers for BMGN–Low Countries Historical Review, as well as John, for their comments on this paper.

2 Volker Hess and Benoît Majerus, 'Writing the History of Psychiatry in the 20th Century', *History of Psychiatry* 22:2 (2011) 139–145 DOI 10.1177/0957154X11404791.

3 Jennifer L. Bazar's PhD is a powerful plaidoyer to integrate the history of material culture into the historiography of psychiatry: J.L. Bazar, *Objects of Daily Life: Materiality in North American Institutions for the Insane* (PhD York University 2013).

4 I propose here to crossover Alf Lütke's 'Eigen-Sinn' (A. Lütke, 'Geschichte und Eigensinn', in: *Alltagskultur, Subjektivität und Geschichte. Zur Theorie und Praxis von Alltagsgeschichte* (Münster 1994) 139–53) with Appadurai's 'social life of things' (A. Appadurai and Arjun (eds.), *The Social Life of Things: Commodities in Cultural Perspective* (Cambridge 1986) DOI 10.1017/cbo9780511819582). Several handbooks offer good overviews over the 'material turn' or refute this terminology such as D. Hicks (ed.), *The Oxford Handbook of Material Culture Studies* (Oxford 2010) DOI 10.1093/oxfordhb/9780199218714.001.0001. In the recent publication of A. Gerritsen and G. Riello, *Writing Material Culture History* (London 2015),

To address this topic in the field of psychiatry, this article focuses primarily on a local case study. In the 1920's Brussels' politicians decided to build a new psychiatric hospital. Engaging in a broader policy of modernisation through a public building programme, the urban elites of the Belgian capital invested heavily in the city's medical infrastructure - Saint-Pierre Hospital (1921), Brugmann Hospital (1923) and Jules Bordet Institute (1939) being noteworthy examples.<sup>5</sup> The imposing materiality of these medical institutions crafted a powerful statement with regard to the extent of the autonomy exercised by the local elites. The *Institut de Psychiatrie*<sup>6</sup> is but a minor example of this larger phenomenon. Nonetheless, caring for those afflicted with madness had been a long-standing tradition among urban communities down through the centuries.

In this essay, I will reflect upon material culture in this newly constructed medical space, as perceived through the prism of three commonplace objects - *a wall*, as a symbol of confinement, *a bed* as a symbol of a standard hospital fitting and *a pill*, as a symbol of therapeutic hope. These three objects epitomise psychiatric practice without reducing it in any way to its medical function.

### Erecting Walls and Living Within

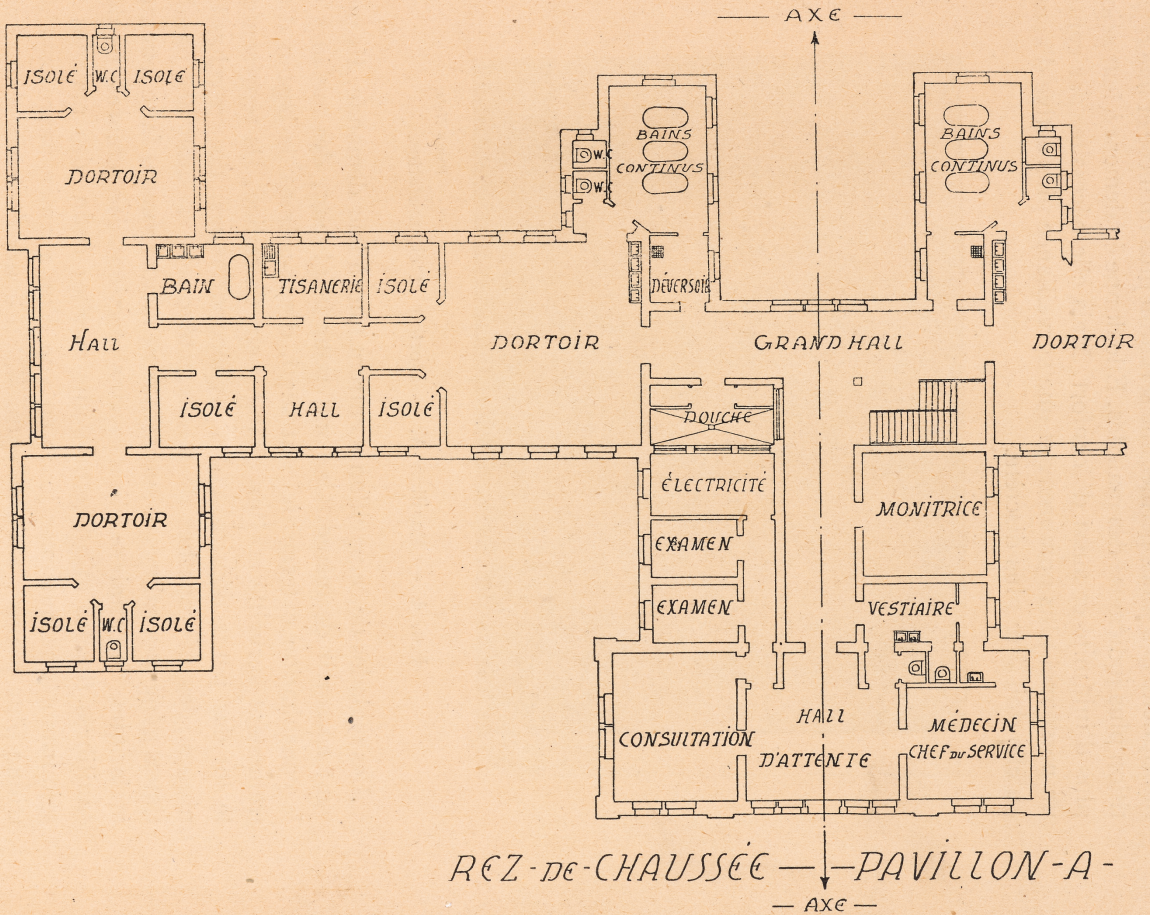
The increasing tendency towards confinement in psychiatric institutions<sup>7</sup> in the latter half of the nineteenth century – in Belgium, for example, the number of interned patients soared from 6228 in 1858 to 16270 in 1900<sup>8</sup> – rapidly elicited a torrent of criticism concerning asylums and their practices. Fuelled by former patients' autobiographies, personal accounts

the authors do focus more specifically on the challenges for historians.

- 5 A. Lelarge (ed.), *Du Monumental au Fonctionnel: l'Architecture des Hôpitaux Publics Bruxellois, XIXe-XXe siècles: Ambitions et Réalisations* (Brussels 2005).
- 6 To facilitate the writing and reading of this article, I will therefore use the term 'Institut' in italics to denote the Institute of Psychiatry of the Brugmann Hospital in Brussels. This institution, founded in 1931, is still active today as the psychiatric department of this academic hospital of the Belgian capital.
- 7 The materiality of the buildings has already produced a stimulating historiography, among

others H. Johnson, *Angels in the Architecture: a Photographic Elegy to an American Asylum* (Detroit 2001); A.M. Beisaw and J.G. Gibb, *The Archaeology of Institutional Life* (Tuscaloosa 2009); C. Coleborne and D. MacKinnon, *Exhibiting Madness in Museums: Remembering Psychiatry through Collections and Display* (New York 2011) DOI 10.4324/9780203807101, but is mostly limited to the nineteenth century.

8 W. Van Waesberghe, 'Het Belgische Krankzinnigenbeleid in de XIXe eeuw', *Annales de la Société Belge d'Histoire des Hôpitaux et de la Santé Publique* 22 (1984) 69-96.



The left-wing open ward for women.

*Journal de Neurologie et de Psychiatrie*, 32:1 (1932) 37.

Special Collections, Library University of Amsterdam.

by disillusioned psychiatrists as well as legal scandals in the wake of abuse and death, publicly questioning psychiatric practices was to become commonplace in Western Europe. Even if a small number of sizeable asylums were still being built during the interwar period in Belgium, it was becoming increasingly inconceivable, particularly for an elite that considered itself both liberal and modern, to embark upon the construction of a typically classic asylum structure in the late twenties. In 1922 members of this Belgian urban elite founded the *Ligue belge d'hygiène mentale*, the primary objective of which was to promote psychiatry beyond the confines of the traditional asylum.

The walls of the *Institut* thus were meant to reinvent and reconfigure, at least partially, psychiatric space. The *Institut* was but one section of a larger, general hospital, the Brugmann Hospital established in 1923. Though located on the perimeter of this medical complex and having a separate entrance, it nonetheless remained part of a larger hospital structure that was not enclosed by walls. The *Institut* was comprised of two pavilions – one with two open wards and the other with four closed wards – that together housed around 100 beds. Compared with other medical units, this number of beds was impressive, but still rather limited for a psychiatric institution.

Not only did the *Institut* have closed wards, it also had two open units – one for women, the other for men – a fact for which Belgian law did not explicitly provide.<sup>9</sup> The name given to this psychiatric space was not ‘lunatic asylum’ (*asiles pour aliénés*) but ‘Institute of Psychiatry’, thus highlighting the medical speciality practised within its confines, while no longer emphasising the fact that patients were interned behind walls.

How was this drive towards reformation reflected in the buildings’ materiality? Two figures left their mark on the transformation from the envisaged model to the constructed edifice – the future director of the *Institut*, Guillaume Vermeylen, and Georges Vellut. Vermeylen was a young psychiatrist, member of the aforementioned *Ligue belge d'hygiène mentale* and one of the rising stars in Belgian psychiatry in the thirties. Vellut by contrast, was a trained engineer who had been working for the Public Assistance Commission of Brussels since 1902 and previously responsible for building several medical institutions in the city.<sup>10</sup> Vermeylen and Vellut visited hospitals and asylums throughout Belgium and Europe. For almost a year

9 Contrary to most of the Belgian asylums, the *Institut* did not establish a social differentiation. This had at least two reasons. First, patients did not stay very long at the *Institut*. Most of the chronic patients were quickly transferred to provincial asylums. Secondly, as the *Institut* was financed by the Public Assistance Committees of Brussels, the population was therefore mainly

from middle and lower class: B. Majerus, *Parmi les Fous. Une Histoire Sociale de la Psychiatrie au 20e Siècle* (Rennes 2013) 85-97.

10 Too often historians focus on the psychiatrists instead of the architects and engineers, see for example C. Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis 2007) 9.

they pursued extensive epistolary exchanges, discussing the various material elements to be used in construction. Both agreed that it was no longer possible to build psychiatric walls as before: ‘The overall appearance must be simple and pleasant, and nothing should suggest the idea of constraint and deprivation of freedom.’<sup>11</sup> Yet, the confinement paradigm remained deeply ingrained in their thinking about the materiality of the new buildings.

While Vellut wanted windows to function as a means for confining patients, their appearance was meant to be as traditional as possible. Over several months he corresponded extensively with several Belgian and British frame manufacturers. The archives at the *Institut* are full of advertising leaflets offering various proposals and solutions for window design. This episode opens up a whole new dimension normally absent from the historiography of psychiatry, namely the role of (medical) craftsmen and manufacturers. These epistolary exchanges render visible an economy that produced devices mainly conceived for hospitals and prisons.<sup>12</sup> Invariably absent in historiographical narratives on psychiatry, these craftsmen were often to determine the buildings’ materiality in a distinctly practical manner. However, they did not propose a satisfying solution for Vellut. So, he himself designed a new ‘fixed frame with opening parts meant for use in an insane asylum’.<sup>13</sup> To avoid giving the impression of being confined, an iron frame was concealed behind a wooden frame. While this type of window would provide a fairly tight barrier preventing patients from escaping, it should also allow air to circulate.<sup>14</sup> Although the miasmatic theory had been replaced by the germ theory in the latter half of the nineteenth century, the notion of ‘air flow’ remained a salient architectural concern for engineers, physicians or architects in the first half of the twentieth century. Hence, Vellut designed windows that allowed the air to circulate freely, but not the patients. Another distinguishing feature of the *Institut*’s windows was that they were made with sheets of float-glass and not normal glass, which was considered as too easily breakable.<sup>15</sup>

The tensions between confinement and liberty were also palpable in the garden design. Gardens were a commonplace feature in most asylums built in the second half of the nineteenth century and had a threefold

11 Guillaume Vermeylen, ‘L’Organisation Médicale, 34.

12 In the Belgium of the fifties, more than 40 percent of the 57,000 hospital beds were in psychiatry. René Sand, ‘Le problème hospitalier en Belgique’, *L’Infirmière*, 30:6 (1952) 18–20. The percentage of psychiatric beds was even higher in the interwar period. Asylums were thus the most important market for these manufacturers.

13 ‘...châssis fixe avec parties ouvrantes, pour un Asile d’Aliénés’, Archives du Centre Public d’Action Sociale de Bruxelles (hereafter ACPASB), travaux, box 30, letter from Georges Vellut to a craftsman (20 November 1928). All translations are by the author.

14 ACPASB, travaux, box 30, note by Georges Vellut (5 January 1928).

15 ACPASB, travaux, box 30, meeting of the *Conseil supérieur d’hygiène* (31 March 1928).

function: firstly, by their design and layout, they should calm people enduring a world characterised by modernity (speed, noise, light and so forth) and who suffered from their ‘nerves’. Moreover, gardens on occasion performed an economic function: several asylums were partially self-sufficient institutions thanks to their considerable vegetable plots. Finally, gardens also had a classificatory function in that they reproduced the categorisation and separation between men and women within the asylum system, between agitated and calm patients, between affluent and needy patients. In most asylums the garden was enclosed by walls to prevent inmates attempting to escape, and moreover, to protect patients from the public’s prying eyes. Nevertheless, the use of (visible) walls was to be avoided so as to express the *Institut*’s modernity. In a letter to the Public Assistance Commission responsible for financing the construction, Vellut argued:

Vermeylen considers it necessary to create four gardens, two designated for the open wards and two for the interned patients, one section of the garden being assigned for men and the other for women. This arrangement has the great advantage of creating walled gardens for each wing of the two pavilions. [...] These gardens must be designed in such a way, in his opinion, to prevent any visual contact between men and women. Mr. Vermeylen does not favour fenced-in cages, as in the older institutions, but wants instead to install a wire mesh fence at a height of between 1m70 and 1m80. This fence could be concealed, for example, by a tall privet hedge reaching the same height.<sup>16</sup>

The garden space was thus considered as an extension of the practice of categorisation and differentiation that took place within the hospital walls. As with the two pavilions, the garden was primarily organised around the two core categories - gender and danger -levels. The garden architect, Jules Buysen, who previously designed gardens for the orphanages of the city of Brussels, hoped that ‘by spreading beauty amongst the sick, their morale will be lifted’.<sup>17</sup> Garden architects and asylum directors shared many beliefs - nature as a cure-all, the necessity of therapeutic exercise and that urban life was the source of every form of vice.<sup>18</sup>

Doors, albeit less visible, were another specific psychiatric instrument but nonetheless pivotal in confining therapeutic space. Their construction presented engineers with a twofold problem: they needed to create doors and locks that could resist any attempt by the inmates to escape. Hence, all exterior and interior doors were fitted with a dual-tumbler lock, and yet, effective partitioning should not in any way impede free movement by the medical and

16 ACPASB, travaux, box 31b, report by Vellut for the PAC (11 June 1930).

17 ‘...en répandant la beauté autour des malades leur moral soit relevé’, *Le Soir*, 25 June 1934, 2.

18 C. Yanni, *The Architecture of Madness*, 9.

nursing staff. This entailed doors needing locks that are ‘absolutely identical to one another, so that they can all be opened with a master key’.<sup>19</sup>

The historical narrative concerning psychiatric space often draws to a close at this level – a history confined to the intended and built spaces. However, there were permanent tensions between these two spaces and the inhabited space. ‘The appearance of complete freedom’, of which Goossens-Bara, President of the Public Assistance Committee, spoke in his inaugural speech in 1931 afforded the inmates numerous opportunities of escape. These breakouts, in turn, led to security measures being intensified. Nevertheless, the idea of invisible confinement remained the guiding principle. Regarding the fencing

in the garden for patients at the Institute of Psychiatry, Dr. Vermeylen argues that it is necessary to reinforce the thickness of the hedgerows in the garden where the patients walk placidly, but not to raise the height of the fence. This reinforcement should be done by expanding the privet hedge and by placing a second row of stakes with barbed wire behind the hedge. It is especially important, in Dr. Vermeylen’s view, to renew most of the flowerbeds in front of the fences. Dr. Vermeylen attaches great significance to the moral barrier posed by these flowerbeds [...] Professor Vermeylen believes in this method’s therapeutic effect for the patients: by not giving them the impression of being confined, by creating the appearance of being in a non-enclosed garden where flowers and greenery are the only obstacles they have to cross.<sup>20</sup>

To increase the effectiveness of such confinement, two invisible strategies were pursued: one involved ‘soft’ barriers – formally planted not as a border, but rather for reasons of embellishment – and yet visible, and the ‘hard’ barriers, partly concealed, such as barbed wire embedded in the hedges.

This inclination however, for invisible control was not applicable everywhere, as was to become evident when toilet facilities were being installed in the gardens. In order to avoid patients returning inside the pavilion to meet their needs and thereby escaping nurses’ supervision, the Infrastructure Department at the Public Assistance Commission proposed the following solution: ‘These toilets must be built in such a way to allow easy monitoring (a door that opens both at the top and at the bottom) – without a doorknob, a door that opens in either direction, but can be locked from the outside, without a chain for the flush and with an exterior light switch’.<sup>21</sup> The toilet had a particular status throughout the institution. Sometimes

19 ACPASB, travaux, box 30, specifications for the Institute of Psychiatry.

20 ACPASB, AGP-CAP, box 158, letter of Vermeylen to the Public Assistance Commission (1 October 1936).

21 ACPASB, travaux, box 219, letter of the director of the Brugmann hospital to the PAC (5 July 1938).



it was a space for humiliation, as can be witnessed in the documentary film *Titicut Follies* (1967) by Frederick Wiseman, in which patients had no privacy whatsoever, but it could also be a place that afforded them a sense of liberation. It was a space where a patient could not only retreat from fellow patients, but also from the medical and nursing gaze. At the *Institut* everything possible was done to curtail this freedom. There was partial visibility because the door panel was not completely closed; it was not possible to lock the door from the inside due to the absence of a doorknob; there was no key on the inside and the door could be opened in either direction. The toilet's materiality illustrates the paradoxical tensions and limits inherent in the 'perceptual economies.'<sup>22</sup> A water-closet is initially conceived as a space giving some intimacy. The inmate (mis-)uses it to escape surveillance by confining himself in an already confined space, an archetype of 'secondary adjustment', as defined by Goffman.<sup>23</sup> The authorities' reaction could be called a 'tertiary adjustment', by redefining the toilet as a transparent and open space.

Dating from 1938, this strategy for building toilets formed part of a re-modelling of the *Institut*, whose objective was to make the psychiatric space more secure. In 1950 Bulgomme rugs were placed between the beds of agitated patients in the closed wards. In the same year radiator covers were installed following an incident in which a patient seriously wounded himself while banging his head against a radiator. Such examples indicate a steady process of 'learning' from psychiatric space and consequently reconfiguring it. Focusing on its materiality allows us to counterbalance an often-static history of psychiatric spaces, which does not pay close attention to diachronic changes.

### The Bed

During the eighteenth century beds became a characteristic feature in hospitals. In the second half of the nineteenth century, psychiatrists, in their efforts to integrate in the medical field, organised their wards around beds.<sup>24</sup> Thus, when political and medical elites discussed the capacity of the *Institut*, they referred to '116 beds', and not '116 patients'. A bed had a 'daily fee' and

22 Ch. Otter, *The Victorian Eye: a Political History of Light and Vision in Britain, 1800-1910* (Chicago 2008) 91 DOI 10.7208/chicago/9780226640785.001.0001.

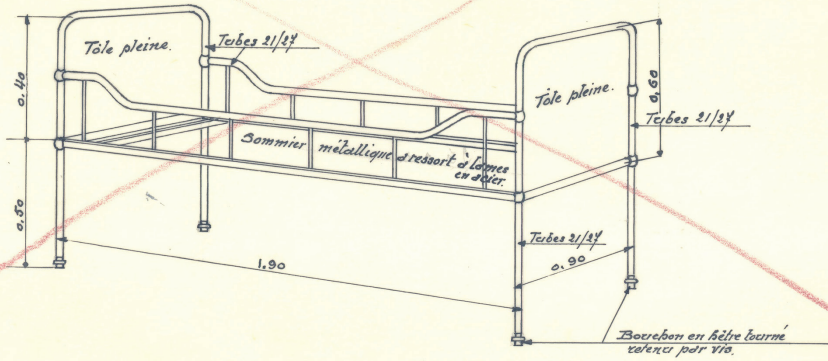
23 Erving Goffman defines 'secondary adjustment [...] as any habitual arrangement by which a member of an organization [...] getting around the organization's assumptions as to what he

should do and get and hence what he should be'.  
E. Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth 1961) 189.

24 Geertje Boschma, *The Rise of Mental Health Nursing : a History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam 2003) 65-67 DOI 10.5117/9789053565018.

Plan à Amsterdam  
avant de le faire  
copier.

Commission d'Assistance Publique.  
de la Ville de Bruxelles  
Dessin des lits en fer pour l'Institut de Psychiatrie.



Project for a psychiatric bed designed by Georges Vellut.  
Archives of the Collections of the Public Social Welfare  
Centre, Brussels.

‘annual costs’, which allowed budget comparisons between various units and the risk calculation of over- or under-population. Reform of psychiatric hospitals from the sixties onwards took place under the motto ‘reduction of psychiatric beds’. Hence, the bed was an object adapted to concepts and usage within the *Institut*.

At first glance, the bed designed by Vellut seemed similar to those in other units at the Brugmann Hospital. Built of iron with rounded shapes, it was immediately identifiable as a hospital appliance. Certain details however, defined it as a psychiatric object. At the *Institut*, this specificity was notably visible because the psychiatric wards formed part of a larger institution, namely, the Brugmann Hospital. Hospital management constantly engaged in comparisons between a ‘normal’ unit and those at the *Institut*, comparisons that led to differentiation and not the assimilation of psychiatry into the rest of medical practice. The general medical director repeatedly emphasised the need to take into account the psychiatric specificity when considering the materiality of everyday hospital appliances – beds, bedside tables, shelves and so forth.

Georges Vellut initially contacted the Ministry of Justice to enquire about prevailing practices in other asylums; the responsible department advised him that beds were to be fixed to the ground, because ‘the Institute of Psychiatry [...] admits all sorts of sick people: restless, violent, suicidal’.<sup>25</sup> The administration thus stuck to the opinion that generally featured in most psychiatric handbooks. ‘Beds are fixed to the ground. This convention is made necessary due to violent outbreaks, in which patients might turn the bed upside down’.<sup>26</sup> Yet, it was precisely this immobility that made Vellut opt for another solution, based on his contacts with the Lovenjoel asylum.<sup>27</sup> The Reverend Mother at Lovenjoel, more concerned with the daily administration of her asylum than with theoretical reflections concerning mental patients, recommended mobile beds. These not only allowed an optimisation of space in times of overpopulation, but also greatly facilitated cleaning the floors. However, in order to stabilise the beds somewhat, Vellut availed himself of a stratagem proposed by the aforementioned Reverend Mother: the beds were built ‘with round wooden legs instead of casters, which afforded relative fixity’.<sup>28</sup> Furthermore, unlike beds in other medical departments in the same hospital, those at the *Institut* did not have bars at the head and base of the bed,

25 ACPASB, travaux, box 30, letter from Dom to Vellut (16 November 1929).

26 R. Mignot and Ludovic Marchand, *Manuel Technique de l'Infirmier des 'Établissements d'Aliénés* (Paris 1931) 306.

27 The Lovenjoel asylum was one of the largest psychiatric hospitals in Belgium. Managed by a

religious congregation, it served as the teaching hospital for the Catholic University of Leuven.

28 ACPASB, travaux, box 30, letter of Reverend Mother of Lovenjoel to Georges Vellut (23 November 1929).



Commission d'Assistance Publique de Bruxelles - Hôpital Brugmann  
**Institut de Psychiatrie** - Section fermée - Dortoir (vue vers l'entrée).



Postcard from the ward for agitated patients at the *Institut* (1931).  
Archives of the Collections of the Public Social Welfare Centre,  
Brussels.

but instead were made with full panels so as to prevent suicide attempts by attaching sheets to the bars.<sup>29</sup> They were also built in such a way that boards could be attached to hinder patients getting out of bed. To avoid the risk of burns, cuts and electrocution, the beds were not equipped with a small light as in the other units. If an inmate had a bed with a bedside table, he then did not have a wardrobe, unlike other patients in the Brugmann Hospital. Clothing belonging to psychiatric patients was stored in individual lockers in the basement of the *Institut*, to which the inmates did not have access.<sup>30</sup>

Until the sixties patients were routinely put to bed upon admittance. This practice served several functions. The bed was primarily a symbol of hospital life in general: being confined to bed during the day was automatically associated with being sick. The bed became a symbol of disease and illness, and therefore its use also meant that insanity should be included in the interpretive scheme of the disease, and not in that of social deviance. It was also seen as a means of disciplining the body and of defining space at a time most patients were not allocated private rooms, but had to share large communal wards. At the *Institut* these wards theoretically accommodated eighteen patients.

Similar to other postcards in this series, this one shows us an ideal ward – devoid of patients. The beds were set perpendicular to the walls, creating a wide corridor facilitating rapid movement through the halls. Between beds was the space necessary for a doctor’s ward round, but also enough to prevent patients from touching each other.

Interspersed with neatly arranged beds, the ward’s spatial organisation was meant to reflect order and cleanliness, This was true of medical facilities in general – most photographs of medical wards during this period show beds meticulously lined up in rows<sup>31</sup> - but even more so in psychiatric units, where the bed constituted a crucial tool in controlling patients. In their psychiatric handbook, the physicians Mignot and Marchand advanced a similar argument: ‘Beds must be wide enough apart so that a patient cannot reach by hand a patient in an adjacent bed; beds should be at a distance from walls; nurses must be able to circulate around the beds in order to contain the restless during their excitable outbreaks’.<sup>32</sup>

By putting a patient to bed doctors ensured ‘order’ in what otherwise risked being turbulent wards, thus performing a classificatory function with this provision. However, the envisaged order regularly encountered

29 ACPASB, travaux, box 31b, letter from Dom to Vellut (16 November 1929).

30 ACPASB, travaux, box 30, file related to the manufacturing of 144 iron lockers for the *Institut*.

31 Robert Bogdan and Ann Marshall, ‘Views of the Asylum: Picture Postcard Depictions of

Institutions for People with Mental Disorders in the Early 20th Century’, *Visual Studies* 12:1 (1997) 4-27 DOI 10.1080/14725869708583772.

32 Mignot and Marchand, *Manuel Technique*, 307.

quite a different reality. From the fifties onwards the *Institut* had to deal with permanent overcrowding. The rules and conventions, as set out in the psychiatric handbooks (inter alia, concerning distances between beds) could no longer be met. The room's organisation, which was originally meant to assist in combating the inmate's mental disorder, was disrupted. A documentary film on the public Belgian television revealed the extent of the massive overcrowding at the *Institut* in the sixties. Beds were so close to each other that the large hallway no longer served as a space for circulation. Despite maintaining a semblance of symmetry, the ward was brimming with tension. The bed, initially conceived as an object to establish order and to facilitate the unhindered circulation of personnel, had become unwieldy.

For many psychiatrists a bed embodied a therapeutic value. Lying down on it, it was believed, led to the nerves being relaxed. Induced by modern urban life, high levels of excitement to the human nervous system were considered as one of the most substantial explanations for the apparent increase in the number of mental patients. In addition to this physiological argument, the bed also had a psychological function - to reproduce the illusion of a 'regular' hospital and hence to convince the inmate that he was sick, and consequently to confer the same legitimacy to the asylum and to the psychiatrist as a 'regular' patient would to a general hospital and to other physicians. From the perspective of the nurses/keepers, accepting being put to bed in daylight was an indicator of the degree of a newcomer's obedience. Gian Maria T. immediately complied with the rules during his seventh stay at the *Institut* in 1956: 'Came in at 1:30, clean clothes and clean body, responds well to questions, said he drank 20 glasses of beer and half a litre of alcohol; had been here 4 years ago, received Br. Chl. [Bromine monochloride]. On demand, goes obediently to bed'.<sup>33</sup> This was often the point the patient was initially confronted with the practical constraints of institutional life. Bruno B. was admitted in February 1933 to the *Institut* for issues related to alcoholism. He remained for 22 days in a closed ward, before returning to his family: 'Admitted at 11 am, was calm and put to bed. Angry because he must stay in bed. Afterwards more agitated. Yelled, was given a bath for 3h30, received purge. Bath given by Miss M.'<sup>34</sup> In Bruno B.'s case, and he was by no means unique, the inmate considered being put to bed during the day as infuriating and provoked his ire against regulations. From the day of his admittance the inmate was instantly confronted with limits to his freedom and the coercive capacity of the nursing staff. In the case of Bruno B. the consequences were quite severe: he was only allowed to leave the bath after 48 hours and remained tied to his bed for another day. Putting inmates to bed on admittance was only mandatory in the closed wards; in the open wards patients could circulate freely in the dormitories

33 Hôpital Brugmann – Institut de Psychiatrie (hereafter HBIP), Ancienne Série (hereafter AS), nr. 4530, nursing notes (9 September 1954).

34 HBIP, AS, nr. 4530, nursing notes (4 February 1933).

and establish contact with other inmates. The bed was clearly designed as a 'device of the total institution'<sup>35</sup>, a disciplinary tool.

Various reforms and (apparent) therapeutic ruptures impacting upon psychiatry in the 1950s and 1960s were responsible for transforming the bed's function. Thereafter, the psychiatric hospital, at least in theory, began promoting reintegrating patients into society and considered implementing this strategy as one of its primary tasks. *Intramuros*, hospitals tried to simulate life- and work-conditions in the outside world. Staying in bed during the day was no longer judged desirable. While the bed arrangement continued to order the space available on wards, the nursing and medical staff no longer systematically obliged patients to stay there for protracted periods. Resting in bed – an 'activity' considered as unproblematic during the interwar period – became a worrying symptom from the sixties onwards, when activities such as occupational therapy gained traction in the asylums.

It was only at that juncture that another reality became ever more visible in the doctors' and nurses' notes - the bed as the primary private space available to the inmate. It was often the only space specifically devoted to the individual. All beds were indeed alike and it was strictly forbidden to customise them, at least until the fifties. Each patient was nonetheless designated a specific bed upon being admitted to a ward and rarely switched beds during a hospital stay that could on occasion last several months. The patient could withdraw to bed where he had sheets under which he could 'hide'; the institutional space, as such, was 'colonised'<sup>36</sup> by the inmates. In fact, it was due to the dogged resistance of those patients who did not want to get out of bed, despite the therapeutic changes made in the sixties, that this appropriation became visible to the historian. The functionality of an object is therefore never a given: it constantly changes; it is repeatedly contested and redefined. A permanent tension exists between the envisaged, the manufactured and the inhabited bed.<sup>37</sup>

### The Pill

Contrary to widespread belief, drugs did not arrive in psychiatric hospitals in the 1950s with the emergence of psychotropics. From 1850 onwards, specific psychiatric drugs such as chloral and bromide had made an appearance on

35 Jean-François Laé, 'Le Lit, Dispositif de l'Institution Totale', in: Philippe Artières and Jean-François Laé (eds.), *L'Asile aux Fous. Photographies de Roger Camar* (Paris 2009) 99-117.

36 J. Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian*

*and Edwardian England* (Houndmills 2015) 3 DOI 10.1057/9781137322395.

37 Fiona R. Parrott, "'It's Not Forever': The Material Culture of Hope", *Journal of Material Culture* 10:3, (2005) 245-262, 245 DOI 10.1177/1359183505057151.

the market. These were gradually replaced by opium and morphine, due to their being deemed too dangerous and causing dependency. At the end of the nineteenth century, barbiturates were added to medical arsenal, being judged more efficient and producing fewer side-effects.<sup>38</sup>

Thus, as the *Institut* opened its doors in 1931, drugs were part of daily reality in the hospital from the outset: in 1931, approximately 55 per cent of patients were on medication.<sup>39</sup> Thanks to their very materiality – be it in tablet or syrup form or as an injection – they represented a fundamental break in how psychiatric therapies were administered. Unlike other therapies such as ECT, where the materiality of the device was immediately inscribed in a coercive context, administering a tablet, often orally, required the patient's consent, theoretically in any case. It afforded a patient greater agency, because taking a pill invariably involved momentary negotiation. Its materiality also facilitated greater mobility. Drugs could be administered in a wider variety of spaces and settings, inside and outside the asylum, whereas most other therapies required specific rooms. This held true not only for bath therapy, but also for insulin therapy during which patients had to be isolated from other inmates so that the latter did not become aware of the treatment's violent nature.

Dispensing drugs in the *Institut* was highly ritualised. Prescribed by the physician, the daily management of drugs was the nurses' task. Psychiatrists at the *Institut* often just indicated the maximum dosage on the drug chart, giving nurses, who were the only personnel having contact with the inmates on a daily basis, some margin of manoeuvre. Distribution took place at specific times – at 8 am, at 2 pm and at 8 pm. Aside from meal times, this was a key moment that punctuated the day's proceeding at a time patients were often left alone. Moreover, it constituted an institutionalised moment where patients met staff and negotiated not only the administration of drugs, but it also allowed them to question nurses on other matters about which they were concerned.

Discussing medication also presented patients an occasion to discuss their afflictions. Receiving medications maintained the hope of a rapid cure. Taking medication however, was also a strong indicator that something was gravely amiss. Refusing medication therefore became a way to indicate to the nurse and/or the doctor that the patient considered himself either not ill or no longer so. Joseph R., for instance, was initially interned in February 1958. Diagnosed as 'paranoid', he was given his first Largactil, an antipsychotic, after

38 Stephen Snelders, Charles Kaplan and Toine Pieters, 'On Cannabis, Chloral Hydrate, and Career Cycles of Psychotropic Drugs in Medicine', *Bulletin of the History of Medicine* 80:1 (2006) 95-114 DOI 10.1353/bhm.2006.0041.

39 Benoît Majerus, 'Making sense of the "chemical revolution". Patients' voices on the introduction of neuroleptics in the 1950s', *Medical History* 60:1 (2016) 54-66 DOI 10.1017/mdh.2015.68.



two weeks. Over the following fortnight, his daily dose was quadrupled: from three administrations of 50 mg per day to three administrations of 200 mg per day. Though lacking access to his medical files, Joseph R. realised that his dose was being increased. He repeatedly complained of side-effects. These were not the only reason it became increasingly difficult to convince him to continue taking antipsychotic medication: '[He] wants to leave but wonders how he could manage given his medication had been increased' and several days later: 'Unhappy because his medication has not been reduced and would like to go home.'<sup>40</sup> Convinced that he was not ill, for Joseph R. being administered drugs was a daily reminder that he could not leave the *Institut* at anytime in the near future. This increased dosage was (correctly) interpreted as a sign of his deteriorating condition, a deterioration that implied that his stay would be prolonged.

Yet for some patients, being given drugs was not just a sign of undergoing treatment, but also of the care given to them. Sofia C. was admitted to the *Institut* for the fourth time in September 1954. Hitherto her only treatment had been electroconvulsive therapy. On this occasion however, the psychiatrist decided to have her try a new drug that had just been released - chlorpromazine, the first anti-psychotic medication. She welcomed the cure with great enthusiasm. A letter to a friend reveals her delight:

Since Saturday, as I've said, I have a new treatment with Lacartine [Largactil] 6 per day and from tomorrow Wednesday I'll get an additional injection in the morning to calm me, because I only sleep from 9 pm until 2 or 3 am, and so I stay awake in my bed a long time [...] I'll tell you about the treatment that they give me. In the morning [I get] some Beladomme at about 9 am 1 cup protecum + 2 promenal + 2 lacartine [Largactil] + 3 am: 2 promenal, 2 lacartine, 1 cup protenum 6 am: 2 promenal, 2 lacartine 8 pm: 1 fénergant [Phenergan] 9 am 1 injection + 1 in the morning. So you see that I'm being cared for and that I'm treated very well. In this way I'll leave the hospital completely healed.<sup>41</sup>

In Sofia C.'s case, being given drugs was taken as a sign that the disease was being dealt with.<sup>42</sup> It acted as a synonym for 'good treatment' and was closely linked with the hope of recovery. The widespread use of drugs in psychiatric hospitals therefore led to fresh hopes not only among medical practitioners but also among patients.

The narrative about drugs obliges the historian of psychiatry to go beyond the confines of the asylum: the heterogeneous trajectories of these

40 HBIP, AS, nr. 12225, nursing notes (29 March and 8 April 1958).

41 Ibidem, nr. 10547, letter by Sofia C. to a friend (30 November 1954).

42 The cooperative taking of medication can be a sign for the psychiatrist that a patient accepts a treatment, and thus that a patient is on the road to remission.

objects uncover many other histories that I will only briefly touch upon here<sup>43</sup> - the history of science, economic history, history of consumption to mention but a few. After 1945 drugs in general, and psychiatric drugs in particular, became a scientific object. Leaving behind the ante-chamber of the individual pharmacist or the localised knowledge of a physician, they ended up in medical laboratories surrounded by a transnational community of chemists, biologists and statisticians. Even if the local context of a particular laboratory still plays a decisive role, medical drugs are nowadays thought of and sold in a global context. The concept of purifying active molecules and replicating them through chemical synthesis creates the paradigm of experimentation and a manufacturing process, (apparently) replicable around the world.<sup>44</sup> However, this new paradigm of furnishing evidence relied upon local institutions that were both willing and able to participate in clinical trials. Even if the focus on social psychiatry by Paul Sivadon and Jacques Flament, directors of the *Institut* in the sixties and the seventies, explains why Brussels played no central role in the consolidation of biological psychiatry, traces of these global processes of rendering science can be witnessed in questionnaires in patients' files when the *Institut* took part in several drug trials in the sixties.

Alongside this initial shift, drugs were also transformed from handmade into industrial objects. If molecularising drugs had implications on how experiments and industrial manufacturing were carried out, the supranational commercialisation and distribution involved a standardisation of their materiality, which required, for example, easy and instant recognition. If, to date, no antipsychotic medication has attained the iconic character of Viagra, the Blue diamond pill, the trade dress, i.e. exclusive ownership of the physical aspect of a given product, also played an important role in psychiatry however.<sup>45</sup> It resulted in a form of codification that reformulated more traditional instructions (one teaspoon of syrup) to more up-to-date indications for dosage (in milligrams), a transformation that can be observed on the therapy sheets of the *Institut* in the fifties.

Finally, drugs, thanks to their materiality and their portable nature, could also be used and administered outside the hospital precincts. With other psychiatric therapies this was physically not feasible. With ECT for instance, the devices involved were too expensive and the electricity supply infrastructure too complicated. Malaria therapy required the presence of

43 In a certain way, this article remains partly imprisoned in the institution, which is its (archival) starting point.

44 Laurent Pordié and Anita Hardon, 'Drugs' stories and itineraries. On the making of Asian industrial Medicines', *Anthropology & Medicine* 22:1 (2015) 1-6 DOI

10.1080/13648470.2015.1020745, show that the story is far more complex.

45 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* 365:1 (2011) 83-89 DOI 10.1056/nejmhle1101722.

medical personnel when the patient awakens. The transportable materiality of a pill (syrup or tablet) embodied a psychiatric therapy easily usable outside hospital settings. For some psychiatric drugs, their history was mainly one of use outside institutional walls. If we follow the external trajectories of medications, the permanent tension between the various itineraries of psychiatric drugs becomes manifest - as a medicalised object, inter alia, through the need for a prescription or/and as a lifestyle product. As early as 1933, twenty years before the introduction of neuroleptics, a pill's "mobility" had become a topic of interest within the *Institut*. Jakob V., a sales representative, was suspected of suffering from general paralysis. He was interned three times in the early thirties. As his treatment consisted of drugs, he wanted to leave the *Institut* and move in with his aunt, because his wife with her two children refused to allow him back home: 'I have to stay imprisoned here [...] this is not necessary for the drugs and food, all this I can have there [at his aunt's apartment]'.<sup>46</sup> The ability to use drugs – his therapy – outside the walls was an argument availed of by Jakob V. to plead for his release.

The earliest mention of Largactil, the first neuroleptic, in a patient's files at the *Institut* was when an inmate requested it, because he had previously used it at home. This offers us a glimpse of the importance of the drug's trajectory in the outside world. By demonstrating that mass consumption of psychotropics is also due to the experience of consumer choice and affluence, of production, of diffusion and replication of tastes and styles renders the narrative that psychiatry is an exclusively top-down process far more complex.

A historian of psychiatry who no longer takes the institution itself as its starting point, but decides to follow the trajectory of the various objects which form the core of the institutional life, as in this particular case with medical drugs, will discover new actors within the history of psychiatry. He will enter into new historiographies, hitherto neglected.

## Conclusion

Commonplace objects seem so natural that they are often absent in written and oral records.<sup>47</sup> For a long time historians have overlooked this blind spot, disregarding artefacts and banishing them to the margins of their interests. The histories of three commonplace objects in the *Institut* reveal how much historians could gain by integrating material culture into their historiographical scrutiny.

46 'Ici je DOIS rester enfermer [...] c'est pas nécessaire pour le médicament et la nourriture, tout cela je sais faire tout aussi bien là-bas'. HBIP, AS, nr.1348, letter by Jakob V. to his wife (21 May 1933).

47 Jules David Prown, 'Mind in Matter: An Introduction to Material Culture Theory and Method', *Winterthur Portfolio* 17:1 (1982) 1-19 DOI 10.1086/496065.

Such an approach enables a twofold enrichment of the historiography of psychiatry. First, it makes another reading of the history of the psychiatric institution possible. Focusing on material culture allows one to go beyond a history uniquely zoomed in on the asylum's objectives and architectural organisation. Attention to these objects allows a rethinking of the history of the psychiatric categorisation. By means of these objects, physicians, nurses and inmates ultimately defined what a 'patient' was: until the sixties, psychiatric walls defined who was crazy; psychiatric beds systematised psychiatric space, but one which was constantly at risk of being disrupted by madmen; psychiatric medication was meant to normalise the inmate. The trajectories of these objects within the asylum system not only allow us to focus on ritualised daily life, but also make visible the resistance to this 'normalisation'. A new history of women and men working and living within the walls emerges through the material life of these commonplace objects. 'Doing psychiatry' is no longer a simple top-down process involving a physician on one side, and an inmate on the other, but rather a complex entanglement where power is permanently negotiated by a multitude of professionals and lay people. This materiality thus 'helps restore the agency of people who are often seen as not having one'.<sup>48</sup>

Second, investigating the 'lives' of these objects breaks the confinement of the psychiatric historiography, still often enclosed by and in psychiatric institutions. It is necessary to de-institutionalise the history of psychiatry not just for the second half of the twentieth century<sup>49</sup>, but also for those earlier decades in which asylums seem to have been a domineering force in the psychiatric sphere. The materiality of psychiatric objects obliges historians to examine not only, for example manufacturing processes, often happening beyond the psychiatric walls, but also the heterogeneous consumption practices not limited to within the psychiatric walls.<sup>50</sup> While this change of perspective introduces new actors into the history of psychiatry, it also compels it to forsake its ghetto. Nurses, caretakers, and housekeepers are but one group, albeit a predictable one, who constantly appear throughout the material history of psychiatry.<sup>51</sup> Another sector continually present is

48 Dan Hicks and Mary C. Beaudry, 'Introduction. Material Culture Studies: a Reactionary View', in: Dan Hicks and Mary C. Beaudry (eds.), *The Oxford Handbook of Material Culture Studies* (Oxford 2010) 1-21, 15.

49 Greg Eghigian, 'Deinstitutionalizing the History of Contemporary Psychiatry', *History of Psychiatry* 22:2 (2011) 201-214 DOI 10.1177/0957154x11399499.

50 Ian Woodward, *Understanding Material Culture* (Los Angeles 2007) 35-56 DOI 10.4135/9781446278987.

51 On the historiography of psychiatric nurses: Benoît Majerus, 'Surveiller, Punir et Soigner? Pratiques Psychiatriques en Europe de l'Ouest du XIXe Siècle aux Années 1950', *Histoire, Médecine et Santé* 7 (2015) 51-62. The very interesting fictional autobiography by Mary Dorsan (M. Dorsan, *Le Présent Infini s'Arrête* (Paris 2015) opens with a chapter on a housekeeper working inside a ward for children psychiatry.

that of those engaged in the industrial and commercial world. Aside from the history of pharmaceuticals, these two historiographies rarely interact.

This new material examination that was made explicit by this psychiatric case study also offers valuable insights for other historiographical fields. The shift towards a material approach is especially fruitful in that extensive field of research that gained traction in the sixties and seventies, which focused on institutions as a means of social control and discipline. Without being the ‘golden bullet’, material culture appears as a promising approach to renew narratives in the history of education, of war or of the police as an institution<sup>52</sup>, because it allows nuanced narratives that take into account the structural imbalances of power, while at the same time being attentive to the agencies of all the actors, as well as the failures of the institutional utopias. Through their daily application, adaptation and transformation, material objects play a pivotal role because they are often designed to impose the norms, and at the same time are the means by which these configurations are reframed. Materiality contains a double promise - control and the disruption of this very control.

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52 Karin Priem, Gudrun M. König and Rita Casale, ‘Die Materialität der Erziehung: Kulturelle und soziale Aspekte pädagogischer Objekte’, *Zeitschrift für Pädagogik* 58 (2012) 7-13; S. Audoin-Rouzeau, *Les Armes et la Chair Trois Objets de Mort en*

1914-1918 (Paris 2009); Michael Sturm, “‘Der knackt jeden Schädel’ Überlegungen zur Verwendung des Polizeischlagstocks’, *Werkstatt Geschichte* 43 (2006) 96-108.