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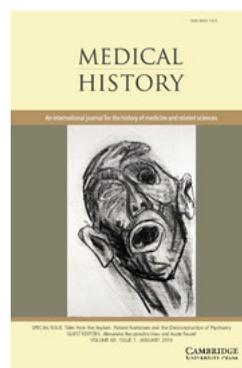
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Making Sense of the ‘Chemical Revolution’. Patients’ Voices on the Introduction of Neuroleptics in the 1950s

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Abstract: The so-called chemical revolution has produced a vast historiographical corpus. Yet the patient’s voice remains surprisingly absent from these stories. Based on the archives of the *Institut de Psychiatrie* (Brussels), this paper traces the introduction of Largactil as recounted in patient letters, physician records and nurse notes. The paper thus contributes to the history of therapies from below, but also participates in the historiographical debate about whether the introduction of neuroleptics can indeed be considered a revolution.

Keywords: Chemical Revolution, Institut de Psychiatrie de Brugmann, Brussels, 1950s, Neuroleptics, Largactil

The so-called ‘chemical revolution’¹ in psychiatry has given rise to much scholarship over the past sixty years.² The introduction of the first antipsychotic (chlorpromazine) in the first half of the 1950s and the first antidepressant (imipramine) in the late 1950s is said to have profoundly changed practices and to have permanently integrated psychiatry into the field of modern medicine. Physicians, sociologists, anthropologists and historians have since engaged in a debate on the purported ‘revolutionary’ nature of these chemical agents³ and on the consequences of their introduction, focusing, in particular, on the following four questions. Was de-institutionalisation, as observed in many western countries, the cause or the consequence of this therapeutic change?⁴ What was the role of pharmaceutical companies in changing definitions of psychiatric nosology?⁵ How have neuroleptics

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¹ Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), 205.

² To cite just three exemplary works that correspond to three particular moments in the debate: Judith P. Swazey, *Chlorpromazine in Psychiatry* (Cambridge, MA: MIT Press, 1974); David Healy, *The Antidepressant Era* (Cambridge, MA: Harvard University Press, 1997); Joanna Moncrieff, *The Myth of the Chemical Cure: a Critique of Psychiatric Drug Treatment* (Basingstoke and New York: Palgrave Macmillan, 2008).

³ Nicolas Henckes, ‘Magic Bullet in the Head? Psychiatric Revolutions and their Aftermath’, in Jeremy Greene, Flurin Condrau and Elizabeth S. Watkins (eds), *Therapeutic Revolutions: Pharmaceutical and Social Change in the Twentieth Century* (Chicago: University of Chicago Press) forthcoming.

⁴ Gerald N. Grob, *From Asylum to Community. Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991).

⁵ David Healy, *Let Them Eat Prozac: the Unhealthy Relationship between the Pharmaceutical Industry and Depression* (New York: New York University Press, 2004).

transformed understanding of mental illness?⁶ And, finally, have scientific methods in psychiatry (for example, double-blind randomised controlled trials, MRI and medical files) been modified based on the above developments?⁷

These discussions have resulted in a vast historiographical output. Specific studies exist for several European countries, tracing the arrival of these drugs on the market and in hospitals.⁸ Over the past fifteen years, an interest in this issue has developed alongside new questions emerging from the fields of science and technology studies (STS) and the history of medicine. Among the lines of research influenced by STS, we find drug trajectories,⁹ the standardisation of pills and syrups¹⁰ and the formation of *Denkgemeinschaften* (Ludwig Fleck), which enable us to analyse the reception of scientific ideas. This probably explains why patients remain absent from narratives, both as key players involved in the discovery of certain chemicals' neuroleptic effects and as objects of their use. Patients have never been at the centre of STS, although they represented a classic topic for social history in the 1970s and 1980s (a stance notably defended by Roy Porter in his seminal article, 'The Patient's View. Doing Medical History from Below').¹¹ Yet the social history of medicine has shown little interest in the second half of the twentieth century, focusing largely on early modern times and the nineteenth century.¹²

Based on the patient records¹³ of the *Institut de Psychiatrie* (Brussels), this paper retraces the use of medication in the 1950s, a time when neuroleptics and antidepressants became an integral part of the therapeutic arsenal. It studies these developments through transcriptions left in patient letters, physician records and nurse notes.¹⁴ The paper thus contributes to the history of psychiatry from below but also participates in the following

⁶ Alan A. Baumeister, 'The Chlorpromazine Enigma', *Journal of the History of the Neurosciences*, 22, 1 (2013), 14–29.

⁷ Viola Balz, 'Die Geburt der Stammkarte. Zur Genese eines Epistems der neuroleptischen Wirksamkeit in der frühen Psychopharmakaforschung in der BRD', *Medizinhistorisches Journal*, 43 (2008), 56–86.

⁸ On Belgium and the Netherlands: Toine Pieters and Benoît Majerus, 'The Introduction of Chlorpromazine in Belgium and the Netherlands (1951–68). Tango between Old and New Treatment Features', *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, 42, 4 (2011), 443–52. On Switzerland: Katharina Brandenberger, *Psychiatrie und Psychopharmaka Therapien und klinische Forschung mit Psychopharmaka in zwei psychiatrischen Kliniken der Schweiz, 1950–80* (Zurich, 2012). On France: Séverine Massat-Bourrat, 'Des phénothiazines à la chlorpromazine: les destinées multiples d'un colorant sans couleur' (PhD thesis, University of Strasbourg, 2004). On Germany: Viola Balz, *Zwischen Wirkung und Erfahrung. Eine Geschichte der Psychopharmaka Neuroleptika in der Bundesrepublik Deutschland, 1950–80* (Bielefeld: transcript, 2010). The only 'Eastern' country to have been studied so far is the GDR: Volker Hess, 'Psychochemicals crossing the wall. Die Einführung der Psychopharmaka in der DDR aus der Perspektive der neueren Arzneimittelgeschichte', *Medizinhistorisches Journal*, 42, 1 (2007), 61–84.

⁹ J.P. Gaudillière, 'Introduction: Drug Trajectories', *Studies in History and Philosophy of Biological and Biomedical Sciences*, 36, 4 (2005), 603.

¹⁰ Christian Bonah, Christophe Masutti, Anne Rasmussen and Jonathan Simon, (eds) *Harmonizing Drugs. Standards in 20th-Century Pharmaceutical History* (Paris: Editions Glyphe, 2009).

¹¹ Roy Porter, 'The Patient's View. Doing Medical History from Below', *Theory and Society*, 14, 2 (1985), 175–98.

¹² Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine*, 20, 3 (2007), 530.

¹³ At the *Institut de Psychiatrie de Brugmann* (Brussels), the entirety of nurses' notes taken three times a day on each patient have been kept in the patient records. On the history of this institute and the composition of the sample (every tenth patient record has been taken into account), see Benoît Majerus, *Parmi les fous. Une histoire de la psychiatrie au 20e siècle* (Rennes: PUR, 2013). To facilitate reading, I will henceforth simply use 'the Institut' when referring to the *Institut de Psychiatrie de Brugmann* in Brussels, which was created in 1931 within a general hospital that had been in operation since 1923.

¹⁴ Until now this point has only been addressed by the historiographical school of the *Charité* (Berlin) that offers an interesting historiographical blend of classic social history of medicine and the STS approach. Viola Balz's book is the most successful example: Viola Balz, *Zwischen Wirkung und Erfahrung*, *op. cit.* (note 8).

two important debates. How can the history of the patient's view enrich classical historical accounts? And how did patients narrate the so-called 'chemical revolution'?

More generally, this article qualifies the Foucauldian concept of the 'medical gaze'. The sources of the *Institut* provide unique access to patient agency, since patients' letters come close to a 'direct' voice that has not been edited by nurses and psychiatrists. These materials reveal that the early users of neuroleptics employed varied and complex tactics to retain control over their experience. At the same time, these patients remained in an institutional order, a medical logic and a pharmaceutical–industrial commodity market, all of which affected their area of agency. Also, this piece highlights the importance of integrating previously neglected players into this historiographical narrative. Since Porter's seminal article, historians have sought to paint a far richer picture, no longer describing psychiatry in terms of the classic asylum–psychiatrists–patient trinity. Typically focused on the nineteenth century, they argue that there was no single response to treatments and practices, but rather a multiplicity of them.¹⁵ Analysis of the unedited patient records of the *Institut de Psychiatrie* during the 1950s shows the importance of staff, outpatients, family members and therapeutic technologies in shaping these clinical encounters. It reveals that the patient–physician relationships are more complex than usually portrayed when it comes to post World War II contexts.

The Introduction of Drugs at the Institut de Psychiatrie

Drugs were not new to asylums in the 1950s. While opium and morphine have long been used in psychiatry, the second half of the nineteenth century witnessed the emergence of a large number of other substances considered more effective and less dangerous, such as chloral and bromides. After the success of these sedatives in the second half of the nineteenth century, the early 1890s saw the rise of barbiturates. These were considered more active and were seen as having fewer side effects than their predecessors,¹⁶ although concerns were regularly voiced about their addictive properties.¹⁷

The use of therapeutic drugs was widespread within the *Institut* ever since its foundation in the early 1930s. In 1931, at least 55 per cent of patients received some drugs during their stay, the most prominent being Luminal, a barbiturate distributed by Bayer. In 1935, this percentage dropped to around 40 per cent; in 1940, it rose to around 80 per cent; in 1945, approximately 50 per cent of patients were medicated; and by 1950, two thirds of them were on some form of medication. Despite the significant variations due to its rather small size, this sample shows that, before the introduction of neuroleptics, more than half of the patients at the *Institut* consumed therapeutic drugs. Well before the 1950s, drugs thus rhythmically structured the daily lives of patients at this institution; and, indeed, the users were well aware of the material nature of these medications. Their distribution – whether in the form of pills or injections – took place two or three times a day and represented

¹⁵ For some characteristic examples, see, eg., Peter Barlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000* (London: Athlone Press, 1999); Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820–60* (Berkeley: University of California Press, 2006); Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills: Palgrave Macmillan, 2004); and Sabine Braunschweig, *Zwischen Aufsicht und Betreuung. Berufsbildung und Arbeitsalltag der Psychiatriepflege am Beispiel der Basler Heil- und Pflegeanstalt Friedmatt, 1886–1960* (Zürich: Chronos, 2013).

¹⁶ 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.

¹⁷ Henri Hoven, 'A propos des intoxications par les hypnotiques. Deux cas d'intoxication par le sulfonal', *Journal belge de Neurologie et de Psychiatrie*, 31, 2 (1931), 67–9.

a moment of negotiation between patients and caregivers. The doctor prescribed the framework within which the drugs were administered (frequency and maximum amount), but every day it was the nurses who decided on these parameters and negotiated the actual taking of the drugs with the residents.

By the time psychotropics entered psychiatric wards, the body language and timing of their distribution had already been codified. The first neuroleptic was introduced into French psychiatry in 1952 under its generic name chlorpromazine; it was sold under the name Largactil. But only in 1954 did the psychiatric field begin to consider the drug as a breakthrough, and its use in most western-European countries began to transcend the experimental framework. That same year, Largactil was administered to the first patients at the *Institut*. At this point, it had been marketed for about a year in Belgian medical journals by Specia, the pharmaceutical branch of Rhône-Poulenc and the Belgian distributor of Largactil. The first accounts of its use appeared in Belgian scientific journals published in 1954. At first, Largactil was not sold exclusively as a psychiatric drug, but also as a treatment for surgery and obstetrics. The emphasis was placed more on 'symptomatic treatment' than on any 'pathogenic specificity', that is, on the drug's effect on symptoms rather than actual healing.¹⁸ Over the years, Largactil was more specifically defined as a psychiatric drug, although the indications for use still remained very broad: 'psychomotor agitation, confusion, anxiety, depression, obsessions, cenestopathy, intractable insomnia, sleep therapy, neuralgia, various pains, dysautonomia'.¹⁹ In the second half of 1954, Largactil was classified as category A by the Belgian National Health and Disability Insurance Fund (*Fonds National d'Assurance Maladie-Invalidité*). This classification offered patients in Belgium a refund of 70 per cent of the drug's cost,²⁰ providing an important argument for its use given the high cost. It should be mentioned that the introduction of neuroleptics happened in a context of collective enthusiasm for medical drugs. Since the triumphant march of penicillin in the mid-1940s, the medical community seemed to find a new miracle cure every year: for example, the first anti-TB medicine (late 1940) and extended spectrum antibiotics. As a symbol of 'postmodern medicine',²¹ the doctor no longer merely affixed a diagnosis, but also healed organic diseases. Neuroleptics allowed psychiatry to participate in this boundless enthusiasm.

In parallel with these discussions at national and international levels and across different arenas – medicine, pharmaceuticals and welfare state – neuroleptics also made their way into asylums at a local level. At the *Institut*, Largactil was used very broadly to treat schizophrenia as well as anxiety and *delirium tremens*. Within ten years, treatment patterns went through some major changes, as indicated in the table below.

¹⁸ Christian Bonah and Séverine Massat-Bourrat, 'Les "agents thérapeutiques"', in Christian Bonah and Anne Rasmussen (eds), *Paradoxes et ambiguïtés d'une histoire des remèdes aux XIXe et XXe siècles* Histoire et médicament aux XIXe et XXe siècles, (Paris: Glyphe, 2005), 51.

¹⁹ Advertisement published, *inter alia*, in several 1954 issues of the *Acta Neurologica et Psychiatrica Belgica*. This process of first defining a drug broadly and then using it more specifically had an exact parallel in the medical field. Although chlorpromazine was first discussed in obstetrics journals as well as in journals of internal medicine or psychiatry, the scientific community gradually established it as a drug intended only for psychiatric patients. This process of specialisation and standardisation took place in an international market and within a transnational scientific community, but it also had particular national characteristics linked to the mechanisms of the different welfare states.

²⁰ Fonds National d'Assurance Maladie-Invalidité, *Rapport général sur l'Année Sociale 1955. 2e Partie. Rapport du service médical* (Brussels: Ministère du Travail et de la Prévoyance Sociale, 1955), 71.

²¹ Edward Shorter, *Doctors and Their Patients: A Social History* (New Brunswick: Transaction Publishers, 1991), 179–210.

	1950–54 (n = 46)	1955–59 (n = 87)	1960–64 (n = 318)	1965–69 (n = 284)
ECT	20%	13%	6%	3%
Psychotropic drugs	24%	68%	82%	86%

Table 1: Psychotropic drugs and electroconvulsive therapy at the *Institut de Psychiatrie de Brugmann* (Percentage of patients receiving treatment).

While Electroconvulsive therapy (ECT) was still the ‘cure’ used most frequently in the late 1940s, it saw a significant and sustained decrease from the second half of the next decade. At the same time, the growing and widening diffusion of psychotropic medication allows for two conclusions. First, never in the history of psychiatry had any treatment experienced such a widespread use; in the late 1960s, nearly nine out of ten patients received psychotropic drugs. Second, their use led to the virtual disappearance of all other biological therapies such as cardiazol and insulin shock therapy. Only ECT retained a negligible share in treatments. These developments had an impact on patient experience as well as on the dynamics among members of the *Institut*.

Medical Notes, Records and Patient Narratives

The detailed nursing notes, taken three times a day, as well as the letters kept in patient records, can be used to gain insight into how patients perceived the change in medication practice during the 1950s. This topic appears in many files. In two thirds of them, a nurse or psychiatrist has noted down the patient’s reaction to the medication. Patient response is extremely heterogeneous and a far cry from clichéd images (depictions of ‘inmates’ being force-fed drugs by doctors on the pay list of pharmaceutical companies or, in stark opposition, the introduction of neuroleptics as a universally hailed innovation).

To be sure, many patients were opposed to taking drugs during their stay. Refusing them sometimes became a tactic of resistance to counter perceived ‘negative power’ of the physicians. The administration of medication – usually at 8am, 2pm and 8pm – was a daily ritual. Since the patients were left to themselves most of the time, this was also one of the few moments when they interacted with the staff. Indeed, administering drugs not only structured the day as an obligatory meeting with the caregivers, but it also represented a moment when an opposition to hospitalisation could be expressed – especially at a time when this still happened mostly without the patient’s consent.

The reasons for this refusal are not always clearly indicated. In 1958, a certain Mill M. entered the *Institut* for the third time in his life.²² A 65-year-old retired officer of the Belgian army, he was not given a very precise diagnosis and the reasons for his admittance cannot be found in his medical records. At no point did the staff take any detailed notes on his consuming any drugs. The word ‘medicine’ appears in one single instance within a more general comment:

The patient refused all food and medicine. [?] Active – bites his fingers – refuses to urinate in toilets. [?] on the hands – claims he has a headache ever since he got here. After the injection at noon, rests on the bed, in a theatrical position, feigns total inertia.²³

²² All patient names have been anonymised. I am grateful to my family and friends who have lent theirs to ‘my’ patients.

²³ Hôpital Brugmann, Institut de Psychiatrie (HBIP), Ancienne série (AS), no. 10455, nursing notes (17 July 1957).

In this note, only the patient's general refusal is mentioned. In a broader sense however, he also rejected most rules in his ward. Mill M. showed a characteristic stance. Not taking one's medication was a way to show a general opposition to one's stay in the hospital, in the same way as a refusal to eat or urinate properly.

For many patients, disease, medication and healing formed a closely interlaced triangle. Taking medication implied that one was ill. It would be interesting to study whether administering drugs helped psychiatrists convince patients of their illness. At the same time, receiving medication offered patients some hope for their approaching remission. Nevertheless, it was generally a powerful indicator that there was a problem. Refusing drugs was thus a way to tell the physician that one did not (any longer) consider oneself sick.

Some patients resisted psychotropics specifically. Joseph R., for example, was a German worker in his forties. In February 1958, twenty years after leaving Germany, he was interned at the *Institut* for the first time. Diagnosed as 'paranoid', he received his first dose of Largactil after two weeks. Over the following two weeks his daily dose was quadrupled from three administrations of 50mg to three administrations of 200mg. Although Joseph R. had no access to his file, he realised that the dose was increasing. It thus became progressively more difficult to convince him to take his pills: 'wants to leave but wonders how on earth he can, considering his medication was increased.' A few days later: 'Unhappy – wants to go home if his medication is not reduced.'²⁴ For this patient who was convinced that he was not ill, the administration of drugs reminded him daily that he would not soon be leaving the *Institut*. The dosage increase was interpreted as a sign of his deteriorating condition, and implied that his stay would be prolonged.

Another frequent complaint for Joseph R. – and others – concerned the unwanted physical reactions of the drugs. Indeed, the first neuroleptics produced quite serious side effects, affecting both patients (who developed tremors similar to Parkinson's disease) and nurses (who developed skin rashes). The medical records regularly mention secondary symptoms commonly attributed to psychotropic drugs from the 1950s and 1960s. These include stomach aches, headaches and sleep problems. Since physicians were not in regular contact with the drugs, at first they paid little attention to these side effects. Before the Thalidomide scandal, which broke out in West Germany and Austria in the early 1960s and then spread throughout Europe, this issue was hardly debated in the public space, and its ethical implications were not discussed among medical doctors.²⁵

At the *Institut* a first sign of concern about side effects appears in a patient record of 1962. After complaining repeatedly about tremors caused by Haloperidol, a neuroleptic that had been produced in Belgium since 1958, Dirk M. caused the head physician to reduce the prescribed dose used by the attending psychiatrist. This earned the physician letters of thanks:

Dear Madam, thank you for your lovely visit and for your fortunate intervention as well as for the Cogentin, crucial in stopping internal and external tremors – the side effects of R1625 [which produced in me a purely artificial anxiety].²⁶

²⁴ HBIP, AS, no. 12 225, nursing notes (29 March and 8 April 1958).

²⁵ Following this scandal, a law on medical drugs was voted in Belgium in March 1964.

²⁶ HBIP, AS, no. 7971, letter to 'Madame Cosijns, Médecin chef de l'institut de Psychiatrie' (3 February 1962), for the parts in between brackets: letter to Duret-Cosijns (6 January 1962). Cited in Valérie Leclercq, 'Le stylo-bille et l'entonnoir. Ecrits et écriture des patients de l'Institut de psychiatrie Brugmann (1931–80)' (MA thesis, Université Libre de Bruxelles, 2009), 94–5.

Dirk M. is not the only patient who linked his medication to physical problems. In February 1955, Karine O. went to the *Institut* for the sixth time with a diagnosis of 'depression'. She had repeatedly received psychotropics before:

There is just one thing that is unpleasant about my health; I sleep very well, but every morning I wake up with a crazy headache. And there is no way to get rid of it even though I dine at 6pm and I go to bed at 10 or 11pm the latest. Lately Dr Dewale prescribed me quatané but with these tablets I only managed to wake up completely at 10 o'clock. While I was working, I always became tired with these drugs and the headaches did not go away.²⁷

It is perhaps not surprising, therefore, that patients should make up various strategies to escape what some of them saw as 'poison':²⁸

[Patient] is to be monitored for taking pills, tries to throw them or hide them between his fingers, under his tongue; basically tries every possible trick, even spitting them into a cup so as to throw them out at the slightest inattention.²⁹

These strategies were not uniformly adopted by all residents. Thirty-one-year-old Christian D. was admitted to the *Institut* in June 1958. The scion of a bourgeois family from Brussels, he had attended university and worked as an artist. The initial diagnosis, 'delirium', seemed to signal a short stay. Very quickly he challenged the authority of the psychiatrist and opposed his forced hospitalisation by writing letters to family members and friends who held influential positions in Brussels' society. In a call to a relative (who also happened to be a physician), he wrote:

I apologise [for this unstructured letter] - they gave me, I should say fed me, "Largasil" [Largactil], a revolting pill that makes it difficult to follow up on two ideas. Since you're a doctor, I hope you can intervene and demand explanations from the doctors of the hospital.³⁰

It was not only the *Institut's* medication practices that Christian complained about. Nursing notes are filled with the questions he raised about his drugs: the reasons for their use, their dosage, their frequency, the point of the treatment, and so on. 'Often enough requests explanations about medications treatment, etc.; would prefer not having to take medication and leave from here.'³¹

Christian D. remained one of the few patients who voiced specific questions about the use of drugs and the reasons for their use. This is certainly related to his social origin. Stemming from the liberal bourgeoisie of the Belgian capital, he challenged doctors' prescriptions. These sceptical questionings had little to do with his 'mental illness'; rather, they are evidence of a social milieu that saw its relationship with the medical world not only paradigmatically as patients, but also as customers. The nurses he had to face throughout the day were not part of his social class in the outside world, and Christian D. seems to have had particular difficulty recognising their authority.

As seen above, patient opposition to the medication also gave rise to a whole range of uses³² to escape treatment. But these tactics of resistance, in turn, encouraged the nurses to develop tactics of their own: a form of knowledge that was obviously not included in their textbooks. To be sure, the records show that patient complaints were often ignored

²⁷ HBIP, AS, no. 10 547, letter by Karine O. to a friend (13 September 1954).

²⁸ HBIP, AS, no. 10 624, nursing notes (9 February 1954).

²⁹ HBIP, NS, no. 6460, nursing notes (19 February 1966). Cited in Julie De Ganck, 'Les antidépresseurs à l'hôpital Brugmann' (Seminar paper, Université Libre de Bruxelles, 2008), 28.

³⁰ HBIP, AS, no. 13 515, letter by Christian D. to a friend (23 July 1958).

³¹ HBIP, AS, no. 13 515, nursing notes (28 July 1958).

³² Michel de Certeau, *L'invention du quotidien. 1. Arts de faire* (Paris: Gallimard, 1990), 89.

by the medical staff. Nursing notes such as the one below (about An S., who was admitted to the psychiatric ward after an 'acute psychotic state')³³ are common:

[Patient] has just complained to the nurse because must take Agarol [Largactil] at night, said it makes her ill, afterwards came complaining that she passes no stool and that it has been lasting all day. Just bored everyone with her supposed constipation.³⁴

It is therefore not surprising that, for some patients, taking drugs became a symbol of the physicians' 'negative power'. Yet refusing medication did not mean escaping medication. Even within the voluntary service, not taking drugs was not an option.

Interestingly, however, a first refusal was not automatically penalised by forced administration (a measure that is nowhere mentioned in this sample).³⁵ When patients acted in a non-compliant manner, the nurses showed flexibility. The case of Gilles S. is typical in this respect. Convinced of suffering from Joubert syndrome, he was admitted to the *Institut* for the first time in November 1954 at the age of forty-three. After a week, he began to be opposed to taking drugs: 'very suspicious, constantly asking why he has to take medication, at first does not want to take them, took them finally, does not sleep yet, calm.'³⁶ These notes are found in several reports. Sometimes nurses were even willing to accept that patients reject their drugs if they remained calm, as shown in the example of Nordin F., diagnosed as 'senile demented': 'Evening refuses his medication [25mg of Largactil] – falls asleep nonetheless.' But these instances remain exceptional, even for Nordin F. Indeed, the following day he refused his neuroleptic once again: 'Did not want to take his larg [Largactil] + phen [Phenergan]. Received 1 amp[oule]. Larg[actil] at 21 o'clock.'³⁷

The nurses' notes remain silent on the means of persuasion used at the *Institut*. Did they explain the effects of the drug? Did they exert some pressure? Were pills easier to administer than ampoules? The records say close to nothing on the strategies and persuasive techniques of nursing and medical staff. They do, however, suggest that, sometimes, the administration of neuroleptics in 1950s psychiatric clinics was due to administrative or practical reasons. In a later file, dating from 1960, a letter from a patient to the League of Human Rights makes explicit the possible strategies for constraint used by medical officers. These included the (more painful) threat of administering the drug intravenously in case a patient refused to swallow the pill:

they wanted me to take a drug called Haloperidol (1625), which they had wanted me to take before and to which I am opposed . . . if you do not take your drug or drugs they make you take them as an injection . . . however, in recent days, they make me take Largactif [Largactil] in large doses. Upon my refusal to take the drug again comes the threat of injections.³⁸

Despite these tensions, records show that not all patients perceived the introduction of these drugs in solely negative terms. For some, being given medication was actually a sign of care. Karine O. (discussed above) was admitted to the *Institut* for the fourth time in September 1954. Until then, the only treatment she had received was electroconvulsive

³³ HBIP, AS, no. 13 500, medical report (9 May 1957).

³⁴ HBIP, AS, no. 13 500, nursing notes (19 April 1957).

³⁵ Even if there was no written convention stating that coercion measures needed to be noted in patient files, it seems that such an unwritten rule did exist at the *Institut*. Thus the use of straightjackets and force-feeding were noted systematically. It is very likely that the forced administration of drugs was also noted down.

³⁶ HBIP, AS, no. 11 055, nursing notes (22 November 1954).

³⁷ HBIP, AS, no. 12 855, nursing notes (6 and 7 December 1958).

³⁸ HPIB, NS, no. 7980, letter to 'Monsieur le Président de la Ligue des droits de l'homme' (24 June 1966); cited in Leclercq, *op. cit.* (note 26), 90.

therapy; but this time, the psychiatrist decided to have her try a new drug that had just been released: chlorpromazine. Karine O. welcomed the cure with great enthusiasm. A letter to a friend shows her delight:

Since Saturday, as I've said, I have a new treatment with Lacartine [Largactil] 6 per day and from tomorrow Wednesday I get an additional injection in the morning to calm me because I can only sleep from 9pm until 2 or 3am; thus I stay awake in my bed, it's long (. . .) I'll tell you about the treatment that they give me. The morning some Beladomme at about 9am 1 cup protecum + 2 promenal + 2 lacartine [Largactil]

+3am: 2 promenal, 2 lacartine [Largactil], 1 cup protenum

6am: 2 promenal, 2 lacartine [Largactil]

8pm: 1 fénergant [Phenergan]

9am 1 injection + 1 in the morning

So you see that I am cared for and that I am treated very well. That way I'll leave the hospital completely healed.³⁹

In this case, receiving drugs was taken as a sign that the disease was being dealt with.⁴⁰ For Karine O. it acted as a synonym for 'good treatment' and it was closely linked to the hope of healing. The introduction of new medication therapies and their widespread use in psychiatric hospitals, therefore, not only led to new hopes within the medical field, but also among patients.

Many of them actually insisted that their physicians prescribe them drugs. We still lack studies on their consumption in private during the 1950s and 1960s, but several patients of the *Institut* did regularly take medication at home. Thus Anne-Marie C. expressed from the first day her desire to receive drugs:

Sick, came in at noon, clean. Would like a room, does not like to talk to other patients. Says she is too tired. Requests a pill because of great stomach pain – cannot be healed. . . . Insists on taking something to sleep, received one pill of [vitamin] B complex at 8pm. Not asleep yet, but calms down at 9pm.⁴¹

In this example, the patient no longer appears as a passive subject who merely waits for the psychiatrist's instructions. Instead, she turns into what we might now consider a psychiatric 'user'. One can even wonder if these attitudes have not become more widespread since the 1980s, when patients came to be represented not simply as objects without agency, but, indeed, as active customers.

Anne-Marie C. was not the only person who had very specific ideas about the therapies that suited her best. In the admission report of Gilles S., suffering from 'oligophrenia' [Joubert syndrome], we find similar comments:

Pat[ient] well oriented in time and space, extremely agitated and anxious, constantly gets up from his bed, despite all the injunctions, asks plaintively for sedatives, or inquires about his release date . . . The examination is constantly interrupted by anxious questions, always the same: "You're surely not restraining me with the belt, I was wrapped like rotten fish . . . give me a tranquilliser and let me out tell doctors" . . . Several times to consultations at the hospital of Etterbeek where one would have given him 1 bottle and tablets.⁴²

Gilles S. had already been interned in psychiatric hospitals by the time he arrived in the *Institut*. During short stays in other asylums, he had experienced and witnessed restraint. But he also gained practice with taking (psychiatric) medicine. As soon as he was admitted, he required a sedative; and to give more weight to his demand, he mentioned his

³⁹ HBIP, AS, no. 10547, letter by Karine O. to a friend (30 November 1954).

⁴⁰ The cooperative taking of medication can be a sign to the psychiatrist that a patient accepts a treatment, and thus that he or she is on the road to remission.

⁴¹ HBIP, AS, no. 1575, nursing notes (22 March 1954).

⁴² HBIP, AS, no. 11055, doctor's report (16 November 1954).

experience at another hospital. For him, taking medication was a way to escape internment: 'Give me a tranquilliser and let me leave.' He was aware of being agitated, but knew that his agitation could be stopped with medication. The administration of the drug was thus perceived, instead, as a possibility for escaping the hold of the psychiatric hospital. Compared to other psychiatric treatments of the time, such as ECT, taking drugs was an act that paradoxically served to weaken the medical grip; this was a therapy that could be administered outside the hospital walls.

For medical staff, there also remained the issue of finding out how much access patients had to drugs prior to their hospitalisation at the *Institut*. The case of Francis C. is a vivid illustration of this phenomenon. His first encounter with psychiatry happened through the consultation service. A few days after his first appointment in December 1953, he was admitted to the *Institut* in January 1954 with a diagnosis of depression. Since he was particularly agitated, Francis was administered hyoscine, a sedative, almost every night. But the drug did not have the desired effect. In fact, for two consecutive nights he destroyed the sheet in which he was wrapped. The attending psychiatrist then prescribed bromide and chloral, two other sedatives, but Francis C. remained very disturbed until his release on 8 February 1954. The two drugs were administered to calm him down and he received five electroshocks. During that first stay, his record remains silent as to how he perceived the medication. During a conversation with his wife, however, it emerged that he had taken Largactil even before coming to Brugmann.⁴³ The case of Francis C. therefore not only poses the question of how many patients had been on medication before entering the *Institut*, but also whether (and how widely) Largactil was distributed outside asylums before being used in those institutions. In fact, the records lack enough detail to provide a precise answer, but they do reveal practices that have hardly been addressed by historians until now: namely, the use of medications outside hospital.

Six months later, Francis C. went back to the *Institut*, this time without a precise diagnosis. His admission was justified on the basis of some very general symptoms: 'anxious states of melancholia. Suicidal ideations. Insomnia. Mental disorders, dangerous to himself.' The man now seemed used to taking medication. Upon admission, he asked for an injection to help him sleep, a request that was denied by the nurse on duty. The following night, he received two tablespoons of Largactil. In late August, after thirteen days, he left the hospital. He came back three years later. The physician made the following diagnosis: 'old agitation, tendency to depression and suicide. Insomnia.' This was the first time he received neuroleptics on a regular basis and after ten days he started to complain. The nurses noted that he 'spends much time resting on his bed'.⁴⁴ The next day the psychiatrist wrote: 'remembers having had ECT in '54 and "it was better than the pills".' The same day, the nurse recorded in the morning: 'Seems a little depressed today, never agrees with what he is given as a medicine – thinks it's too much, also complains of headache.' And at night: 'Around 6pm received 1 Cibalgine – did not want to take (suspicious), said he will be dead tomorrow. Very depressed – cries – falls asleep afterwards.' The next day:

Same behaviour – Rests a lot. The patient is sad and a little anxious. Wonders if he still needs to take his medication for long. Said the doctor had promised him another treatment.⁴⁵

⁴³ HBIP, AS, no. 10 382, conversation with the wife of Francis C. (28 December 1953).

⁴⁴ HBIP, AS, no. 10 382, nursing notes (26 July 1958).

⁴⁵ HBIP, AS, no.10 382, nursing notes (27 and 28 July 1958).

During his third stay and a few days after he had asked several questions about drugs, Francis C. received his first electroshock. From that moment his attitude towards neuroleptics changed radically. Instead of opposing them, he now asked for them:

Very anxious after E. Schock. Remains a little confused in the afternoon. Constantly asks for his injection in evening. Says he cannot sleep without something. Not yet sleeping at about 10pm.⁴⁶

The above indicates that, at a time when therapies were not explained to patients, they could actually appropriate a part of medical knowledge. It is particularly striking, in this respect, that patients often referred to drugs by their names – sometimes even their industrial names, for example, R1625 for Haloperidol. These regularly appear in the files, generally with a more or less correct pronunciation and spelling. (It is to be noted, however, that patients did not describe drugs through their effects: the terms antipsychotics, 'neuroleptics' and 'antidepressants' do not appear in patient writings.⁴⁷) Some even declared themselves psychiatric specialists inside their family circles by virtue of their stay at the *Institut*. Pia M., a young servant girl diagnosed as 'depressed' who stayed thrice at Brugmann while several of her family members also suffered from mental illnesses, once wrote to her grandmother: 'What I was especially happy about is that C[.] and you Granny both take 1/2 a Seresta; which seems to do you well because I found you all 4 very well.'⁴⁸

More generally, these records highlight the varied and complex tactics employed by the various protagonists in this story. Neuroleptics were administered for a number of reasons – reasons that sometimes went beyond strictly medical motives. The nurses were interested in keeping their wards calm or had other practical interests. As for patients, they had some power of compliance or non-compliance, and integrated these drugs into their daily lives and into different understandings of healing. This affected their area of agency. Naturally, elements such as social class often played a role on the degree to which their demands were met by medical staff. In any event, the vast majority of patients who asked for some medication received it. In 200 cases studied in detail, all such requests were responded to positively by the caregivers.⁴⁹

Conclusion

This article has aimed to follow the proposition made in 2007 by Flurin Condrau in his rather pessimistic assessment of the historiography of patients. If historians want to have a voice, he noted, they must 'engage with debates that have raged elsewhere and to claim intellectual, empirical and theoretical importance in the field.'⁵⁰ The few pages of this contribution raise questions linked to four broader debates: the bias due to observing the sufferer solely through the institutional archive, the multiplicity of players in the hospital setting, the critical and often 'anti-psychiatric' genealogy of scholars interested in psychiatric history and the question of whether a historical investigation 'can only reveal what is heard, not what is said'.⁵¹

⁴⁶ HBIP, AS, no. 10382, nursing notes (9 January 1954).

⁴⁷ De Ganck, *op. cit.* (note 36), 28.

⁴⁸ HBIP, NS, no. 9720, letter to 'Ma très chère petite Mamy' (11 February 1968), cited in Leclercq, *op. cit.* (note 26), 100.

⁴⁹ Thus Lilly C., a seamstress diagnosed with 'paranoid schizophrenia' who was moved from a general ward to psychiatry, requested drugs very often when she started to feel agitated. 'The patient is really impertinent. Caused tears and tantrums . . . Recognises that she is much agitated and asked for her injection, which she received at 9pm.' (HBIP, AS, no. 10505, nursing notes, 11 October 1954).

⁵⁰ Condrau, *op. cit.* (note 12), 435.

⁵¹ David Armstrong, 'The Patient's View', *Social Science & Medicine*, 18, 9 (1984), 737.

I would like to return to Roy Porter's seminal article, 'The Patient's View. Doing Medical History from Below'. In this piece the author did not really lay his cards on the table. Indeed, his was far from a plea to consider the patient only within the hospital. Porter aimed further, by also addressing aspects beyond the patient – that is, the sufferer *outside* the hospital. Herein lie also the limits of this article. The wealth of information in the *Institut's* archives allows one to appreciate patient narratives, not only because of the medical reports, nursing notes, and so on that were recorded, but also because of the *Institut's* tendency to archive documents produced directly by patients. These files contain the direct voices of these key players through therapy-related material (for example, drawings and results of writing workshops), but there are also traces that were illegally preserved such as letters that the hospital management decided never to send. Yet our knowledge remains extremely limited on the use of antipsychotics and antidepressants in non-hospital settings, since these practices do not necessarily give rise to archival material. As such, the patient records provide a few small glimpses into what appears to be a high consumption of these new drugs outside the institution.

On a purely empirical level, the integration of the patient's voice into a history of psychiatric medication expands the characters that ought to appear in this narrative. That these now include patients seems obvious, as evidenced by the theme of this special issue dedicated to Porter's seminal article. But the same applies to caregivers, whose central role in patients' accounts should now be clear. In the past three decades, historians of psychiatry have sought to integrate the patient into the classic narrative but still often present it as a dance for two.⁵² It is time to recognise the multiplicity of roles within psychiatric institutions and to include, in particular, the heterogeneous figure of the 'nurse' (for example, guardians, servants, caregivers and nurses). After World War II, when these new drugs spread through the asylum, there was a proliferation of new professions in psychiatry (for example, social workers, psychologists and occupational therapists) who changed the patients' experiences of their stay in psychiatric institutions. If, for the nineteenth century, Roy Porter could still claim that 'it takes two for a medical encounter',⁵³ this is definitely not the case for the twentieth century – especially since this period witnessed the move of medical encounters and healthcare from patients' private houses to hospitals.

The change in scale that often goes along with an interest in patients' attempts to 'make sense' also takes this story to the 'ground level'.⁵⁴ This change of perspective moves away from a medical history that is embedded (as is so often the case) in a sterile and moralising opposition between, on the one hand, a narrative that focuses on the remarkable progress of medicine, and, on the other hand, one that only sees a history of 'rulers and ruled'. This particular historiographical understanding of the past is particularly strong in psychiatry.⁵⁵ The humanities remain strongly marked by this anti-psychiatric genealogy, even more than sixty years after the publication of the two great classical critical studies: Erving Goffman's *Asylums* and Michel Foucault's *Madness and Civilisation*. Integrating the patient as a key player and not just as an object of the medical gaze renders narratives less linear and more complex. The psychiatric ward of the 1950s was certainly marked by an asymmetry of

⁵² For exceptions, see note 15 (above).

⁵³ Porter, *op. cit.* (note 11), 175.

⁵⁴ Jacques Revel, 'L'histoire au ras du sol', in Giovanni Levi (ed.), *Le pouvoir au village. Histoire d'un exorciste dans le Piémont du XVIIe siècle* (Paris: Gallimard, 1989), i-xxxiii.

⁵⁵ See, eg., the contrary analyses of Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997) and Healy, *op. cit.* (note 5).

structuring power. By choosing to focus on daily life, however, we perceive the margins of interpretation and manoeuvring for all those involved: patients, nurses, doctors and families.

This article also questions a particularly strong current among sociologists who emphasise two phenomena: first, that the patient supposedly exists only through medicine, or, in the words of Michel Foucault, through the ‘medical gaze.’ From this perspective, the patient’s experience is only transmitted by ‘a technique demanded by medicine’.⁵⁶ Second, they argue that, over the last hundred years, the voice of the patient has largely disappeared from the medical field, whose representatives no longer rely exclusively on the patient to establish a diagnosis but use other techniques to ‘hear’ the disease without the purported patient bias. However, this story – at least in psychiatry – is more complicated. Psychiatrists still depend largely on the patient’s word to determine the efficacy of psychiatric therapies, particularly with regard to psychoactive drugs, because their effect cannot be fully measured by bodily reactions. Despite the development of tools supposed to decipher mental illness – first electroencephalograms (EEG), then computerised axial tomography (CAT) and magnetic resonance imaging (MRI) scans – this voice from below remains essential for gaining insight into various forms of disease experience and its management and representation.

⁵⁶ Armstrong, *op. cit.* (note 51), 739.