Avoiding violence by technologies? Rectal feeding in German psychiatry, c. 1860–85
Kai Sammet

To cite this version:

HAL Id: hal-00570854
https://hal.archives-ouvertes.fr/hal-00570854
Submitted on 1 Mar 2011

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L’archive ouverte pluridisciplinaire HAL, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d’enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.
Avoiding violence by technologies? Rectal feeding in German psychiatry, c. 1860–85

KAI SAMMET*

University Medical Centre Hamburg-Eppendorf

During the nineteenth century, the use of the stomach tube became the preferred method to treat the insane refusing to eat. But it was not unusual for this practice to result in violence and serious injuries. Especially around 1860, when the discussion of non-restraint in German psychiatry reached its climax, other methods of dealing with sitophobia became the focus of interest. In particular, two psychiatrists who ran a private asylum in Eidenich near Bonn, Franz Richard and Bernhard Oebeke, recommended rectal feeding as a means of avoiding violence and injury. This paper deals with this method and also outlines the different ‘technologies’ used to treat ‘abstinent’ insane patients.

* Address for correspondence: Department of History and Ethics of Medicine, University Medical Centre Hamburg-Eppendorf, Martinistrasse 52, D-20246 Hamburg, Germany. Email: sammet@uke.uni-hamburg.de
example, in 1883 Friedrich Siemens (1849–1935), head of the asylum Ueckermünde in the Prussian province of Pomerania, stated that:

in every asylum the consultations on the abstinent insane, the reports about food intake, the discussions on further measures and the implement-
ation thereof absorb a great part of the daily routine. They demand a considerable amount of physical and mental effort on the part of the physicians and the attendants.5 (Siemens, 1883: 568)

Throughout the nineteenth century, refusal of food was the subject of lively debates in alienist circles, not least because it was closely linked to issues such as violence, behavioural ethics in asylums and the discourse on ‘non-
restraint’ in German psychiatry.4 The discussion of these issues focused on the aetiology, pathogenesis and incidence of sitophobia in different mental disorders and on possible therapies.

This paper outlines a special approach to treating sitophobia:5 rectal feeding which was proposed as a possible substitute for forced feeding with the stomach tube, although the latter was widely recommended as a first choice, but also looked upon as being dangerous. To understand rectal feeding and other approaches to dealing with food refusal (Nahrungswertweigerung), it is necessary to set them against the backdrop of the institutionalization of German asylums in the first third of the nineteenth century.6 At this period, abstinent patients came to the notice of the developing profession of psychiatry which was closely linked with the development of a specific institutional framework, the asylum. Psychiatrists were responsible for their charges, and the threat of death by starvation was a very disturbing factor.

How did they try to deal with this challenge? In short: by introducing and employing different ‘technological methods’.5 By ‘technology/technique’ I mean not only the use of instruments, ‘machines’ and so on (see Kurrer, 1990: 534); ‘technique’ also means ‘plans’, ‘procedural instructions’ and behavioural techniques. So, to treat sitophobia, different techniques or combinations of them were available. First, behavioural instructions: the attendant is given a standard set of rules by which to work, and this implies that he is not free to make use of his spontaneous judgement. These rules can be used as ‘tools’, as a certain modus operandi in similar situations. Second, ‘technique’ means skilled behaviour, routine Handgriffe or sequences of actions, like the ‘technique’ of piano playing or the ‘technique’ of introducing a tube into the nose. Third, apparatuses are instruments or means to standardize treatment. And finally, in the case of rectal feeding, we find a technique which can only be under-
stood in the context of the development of chemistry and physiology, as will be shown below. All these ‘techniques’ were proposed, contested and described in a professional discourse related to the fact that asylums were complex institutions which could only be run with standardization and procedural instructions, and in which newly devised instruments and scientific develop-
ments (though in modified form) were utilized.
Forced feeding with the stomach tube: textbooks, 1860–1920

In examining German psychiatric textbooks published in this period, one sees that forced feeding with the stomach tube was prescribed as a standard method. In 1861 Wilhelm Griesinger (1861: 517) noted that forced feeding was recommended ‘with considerable unanimity’. Nearly three decades later, Richard von Krafft-Ebing (1888: 307) mentioned that forced feeding with the stomach tube could nowadays be accomplished ‘without inconvenience’ thanks to tubes ‘made of soft vulcanized rubber recently available on the market’. In 1915 Alexander Westphal (1863–1941) held that forced feeding was unavoidable in cases of ‘obstinate sitophobia’ (Westphal, 1915: 113).

Finally, shortly after World War I, Wilhelm Weyganndt (1870–1939) saw feeding by gastric tube (Schlundsondenernährung) as the only means in cases of ‘absolute refusal of food’ (Weyganndt, 1920: 116, 145). Most other psychiatrists agreed. Specialized monographs and articles also proposed the gastric tube as a first choice. A critical survey by Pfister (1899) was praised because it recommended the use of the tube as ‘self-evident’ (Anonymous, 1900), and a decade later other authors were also advocating this technique (Krueger, 1912: 339; Mörchen, 1909/10).

But was forced feeding really so self-evident? Was a disquieting problem reduced to a simple technological procedure – if a patient refused to eat, was the stomach tube employed almost automatically? Were possible problems of sitophobia solved on the spot by applying a practice which made a network of actions ‘durable’ in simplifying it to a single technique? Was sitophobia ‘black boxed’? Indeed, in the period around 1910–20, there seemed to be no alternatives to using the tube. In conceiving of the connection between social actions, procedures and apparatuses, Bruno Latour (1991) holds that techniques are used to make social actions ‘durable’. At the end of a process of attempts and negotiations, a single sequence of actions involving human and non-human elements (e.g., instruments, technical instructions) is ‘selected’. One acts in the same way in every new instance of the phenomenon in question. As Nina Degele has put it: ‘On the whole, technology invades human collectives, makes actions durable and therefore takes over regulations of social cooperation.’ A complex chain of actions, involving different elements is made into an ‘actant’, a complex network of (human and non-human) actors. Problems seem to be solved, actions are made ‘durable’, the web of actions – deliberations, attempts, ethical assumptions, instruments and procedural instructions – are ‘black boxed’. These elements have become invisible; former alternatives are not seen any more. The ‘black box’ prevents alternatives, problems and the complexity of the web from being seen. Black boxing is thus the ‘process of closure and stabilizing into which those who believe in the soundness of the technique are drawn’; they make use of it, perhaps even propagandize it (Degele, 2002: 129, 130, 132, 134). So treating sitophobia by forced feeding can be seen as an instance of
‘durability’ and ‘black boxing’: in textbooks, such as those cited in the previous paragraph, students and practitioners were instructed to make use of the gastric tube as the first choice. However, most of the texts were not so uniform and simple, and therefore the ‘black boxing’ was incomplete. Problems posed by sitophobia were often too awkward to be treated in a stereotyped manner, so other techniques were also described, but only recommended as a second or third choice or as auxiliary means. This reflected the discussions on refusal of food in mental illness. German psychiatrists in particular were sceptical about the stomach tube.

**What should be done with a starving patient?**

In 1847 Karl Hergt (1807–89), psychiatrist at the notorious asylum Illenau in the Grand Duchy of Baden, published a paper entitled *Beitrag zu den Handgriffen der Fütterung widerstrebender Kranker* in which he explained in minute detail how to deal with sitophobia:

> The patient is laid down in horizontal position [...], pelvis, shoulders, hands and head are to be held by a sufficient number of attendants. The physician standing by the side of the patient presses the lower jaw with the hand which is positioned under it against the upper jaw meanwhile fixing the middle finger of the same hand between the opened lips at the line where both rows of teeth meet. The forefinger of the other hand, crooked like a hook, is introduced into the free corner of the mouth into the outer mouth cavity and with the help of the [...] thumb, by pulling [...] a pocket is made in which [...] liquid is gradually poured. (Hergt, 1847)

This long-winded description was welcomed by his superior Carl Friedrich Wilhelm Roller (1802–78), then head of the Illenau. He stressed that this use of the hands (*Handgriffe*) helped to avoid two risks of the ordinary techniques of treating refusal of food: first, that of breaking the teeth and, second, the dangers of the gastric tube which the French alienist Jules Baillarger (1809–90) had recently described (Rr, 1847).

Hergt was not the only one to give specific instructions about getting food into the mouth. Specially designed spoons and mouth openers were a challenge to technical inventiveness, and German psychiatrists were very keen to find out about the most recent instruments or procedures. For instance, Theodor Schlemm (1846) brought interesting news from Paris: in the well-known journal *Allgemeine Zeitschrift für Psychiatrie*, he reported on a new gastric tube, invented by Francois Leuret (1797–1851) and made from sheep gut by an intricate process which produced a harmless instrument (Leuret, 1845). Heinrich Laehr (1820–1905) described a mouth opener resembling a face-mask:

> It consists of an elliptic piece of wood or a metal plate into which a hole is drilled forming a sort of mouth. [...] The oval opening is equipped with a
shutter which can be opened from outside to the inside when a spoon is introduced and which is shut immediately to stop the food being ejected. (Laehr, 1850)¹⁰

German commentators looked carefully at reports on the stomach tube and were well informed about problems posed by this technique. Jules Baillarger, a dedicated advocate of the stomach tube (sonde oesophagienne), discussed forced feeding in several articles (e.g., Baillarger, 1846, 1847). Shortly afterwards sceptical comments were published in Germany. Willers Jessen (1823–1912), in a critical review of the 1847 paper, stressed the ‘disadvantages’ of forced feeding (Jessen, 1848: 251) and a few years later Carl Friedrich Flemming (1799–1880) agreed with his Italian colleague Andrea Verga (1811–1895) who was sceptical about forced feeding: ‘He is especially wary, and rightly so, about the use’ of instruments ‘because of the danger of suffocation or serious injury caused by them’ (Flemming, 1850: 659).¹¹

The danger of the introduction of the stomach tube played a crucial role in the reluctance of German psychiatrists to use it, and they were well aware of the possible fatal consequences of the feeding tube. Its introduction often damaged the larynx and pharynx. There was evidence that fatal aspiration pneumonia resulted if the tube was pushed into the trachea instead of the oesophagus – this was not unusual when stiff tubes were used, often equipped with a fish bone as a stylet.¹² Most papers, such as those by Baillarger, discussed limits, conditions and problems of forced feeding in detail. In cases of violent refusal of food intake, only certain manipulations were possible because of the anatomy of the lips, nose, larynx and pharynx and the tissues of the gastrointestinal tract. The intentions of the alienist, the anxiety of the patient, anatomy and technical standards interacted either with each other or against each other. But the dangers of the technique were not the only reason why some German alienists were sceptical about the tube.

Forced feeding was generally regarded as a last resort, and instructions were to avoid violence for as long as possible. Moreover, some alienists disliked using any instruments because this disrupted the relationship between alienist and patient. Heinrich Philipp August Damerow (1798–1866), doyen of the German alienists in the middle of the century, commented on Hergt’s and Roller’s approach (Dw, 1847). To Damerow, using the tube was a pure technical procedure and therefore it must be wrong. He thought that treating sitophobia with forced feeding was an easy way out of solving an interpersonal problem. He had tried to use the gastric tube once, but only because he wanted to threaten the patient by demonstrating that he could overcome the patient’s resistance if he wanted to.

Damerow’s concern was not primarily the use of restraint and violence or possible injuries – he was sceptical about any ‘technical procedures’. He proposed the observance of the old Hippocratic triangle: there was no fixed approach the physician should follow; there was the alienist, the illness and a
patient. Damerow kept up the dogma of ‘individualization’, i.e., no instrument, no drug, no ‘inanimate’ element should be used to influence the patient, and nothing should be a ‘go-between’ between the patient and the godlike alienist. To ‘individualize’ in sitophobia meant not to use stereotyped and standardized procedures. In each case the ingenuity and the spirit of the alienist had to find the way to treat the patient. Damerow argued against ‘techniques’, be it manipulative techniques or instruments. Damerow’s ideal was anachronistic at that time, and he himself was not consistent.

Around the middle of the century the asylum was often conceived of as some sort of ‘organic machine’.13 Roller, in his programmatic writing _Die Irrenanstalt in allen ihren Beziehungen_ (1831), constructed the asylum as a complex organism/machine where inanimate and animate elements, bricks, rules and human beings were combined in such a manner as to put into effect the _telos_ of the asylum: healing and curing. One main instrument was the ‘house rules’ (_Hausordnung_), which had to be extremely precise. It was more than a metaphor when Roller talked of the ‘machine-like operation of the regulations of the house’, for these were one of the most fundamental means of healing (Roller, 1831: 6, 7). According to Roller (p. xiii) the asylum should have the ‘character of an organic [...] totality’. But it was a specially invented ‘machine’, constructed by man-made intentions.14 To accomplish its _telos_, it must be a living organism – a machine in itself is dead and needed animating energy to be kept in action. A living organism had to be imbued with vitality. ‘Only spirit can put life into things’ (p. 71). The alienist was the absolute ruler, the order of the asylum originated from him, and it was his spirit which always renewed order – and thus his _individual_ intervention was crucial in treating sitophobists.

But obviously relying only on the ‘spontaneity’ of the head was not practicable in asylums. Technical procedures or even instructions had to be employed, otherwise the running of a complex institution with its specialization of tasks would have been impossible. As mentioned above, with the establishment of asylums in the first third of the nineteenth century, alienists were for the first time confronted with the abstinent insane. Alienists were responsible for their charges and at that time they usually had to care for about 200–300 inmates, so they had to delegate powers and tasks to attendants and officials. To treat each case of sitophobia individually, as Damerow had thought, was a good, but unrealistic, dream which would only have ended in chaos. Standard practices had to be introduced.

Firstly, behavioural techniques had to be employed. The patient refusing food had to be watched carefully. Did he eat secretly in unobserved moments? Sometimes it would suffice for an attendant to go into the patient’s room, put food on the table and to go out in silence. Some patients ate if a friendly attendant was close by. In any case, one should find out the patient’s favourite dishes. Some psychiatrists thought that only slight pressure was needed. If the patient would sit with others in the dining room,
the desire to imitate could make him to give up his unwillingness to eat. The alienists and attendants had to behave in a watchful, skilled and considered way: before forced feeding was carried out, rules and techniques of conduct had to be followed and these had to be learnt and practised. Treatment of sitophobia thus involved more than just the use of instruments. But what happened if behavioural techniques did not succeed?

**Taking the middle way: rectal feeding**

Rectal feeding was discussed even more extensively than feeding with the gastric tube, but around 1860 this method played only a minor role. Heinrich Neumann (1814–84) held that experience had shown that rectal feeding was only a ‘poor and insufficient substitute for natural feeding’ (Neumann, 1859: 207). One searches in vain for any mention of this method in the first edition of Griesinger’s well-known textbook (1845), but the second edition (1861) includes notes on rectal feeding. He stated that it could be used only ‘in addition’, which indicates that he did not take it very seriously (Griesinger, 1861: 517). However, rectal feeding had certainly been used and recommended by others – the application of *Clysmata nutrientia* or the application of clysters in general was a technique that had been used for centuries. It was utilized either to apply medicaments or, when humoralism was the major theory in medicine, to purify the body (see Zglinicki, 1972). But by the mid-nineteenth century clysters were mostly regarded as not sufficiently nutritional. Nevertheless almost all authors, at least during the 1860s, discussed rectal injections.

Rectal feeding was often included in a complex web of actions before the last resort of using the stomach tube. The opinions of the following authors are typical. Hertg (1877: 819) – by then an advocate of the gastric tube, and thus showing evidence of the new technology made durable – recommended ‘nutritional clysters’ as an ‘imperfect substitute’ only in cases where the stomach tube was a threat to the health of the patient. Similarly Krafft-Ebing (1888: 307) commented that if other means, for example clysters, were not successful in avoiding starvation the stomach tube had to be used. Hermann Krueger (1912: 339) said that ‘one had to try to apply nutritional clysters before one used the gastric tube’. And Alexander Westphal (1915) held that, if persuasion was ineffective and the patient persisted in refusing food, rectal feeding should be used ‘in the first place’ but, if he still resisted, the gastric tube should be used without hesitation. Dealing with sitophobia involved stages of increasingly serious treatment. Rectal feeding would be a middle stage and could avoid violence altogether, so it is not surprising that it was recommended as a first choice at one point in the history of German psychiatry.

The discussion on non-restraint in Germany had reached its climax in the 1860s, having been rejected by most German alienists before then. First
reports had been published in Britain around 1840, and the influential Damerow (1844: xxii–xxiii) described it as a ‘hot-house plant’, understandable only in the light of the abuses which had taken place in Britain. From 1860 there were some advocates of non-restraint, such as Griesinger and Ludwig Meyer (1827–1900), and even those who still condemned non-restraint could not avoid hearing the arguments about it, so the idea became implanted in the minds of German alienists. Forced feeding was becoming controversial because of shocking reports of harrowing scenes, for example, several attendants holding a patient who was shaking his head to prevent the introduction of the cruel tube, and also howling and crying, scratching and biting by the emaciated patient as he/she resisted and became exhausted.

Advocates of rectal feeding: the approaches of Richarz and Oebeke, 1861–85

It is not surprising that some alienists searched for alternatives to forced feeding, and at least two of them – Bernhard Oebeke (1837–1913) and Franz Richarz (1812–87) – applied a method which they publicized enthusiastically. In 1869 Oebeke gave a lecture at a meeting of the Psychiatrische Verein of Rhine Province on the ‘Behandlung der Nahrungswiderweigerung bei Irren ohne gewaltsame Fütterung’; he noted that forced feeding with a tube was mostly used and approved of, whereas ‘in every other respect, rejecting the use of violence and restraint in psychiatry is nowadays the done thing’ (Oebeke, 1871). He praised a procedure developed by Richarz, saying that rectal feeding of abstinent patients ought to ‘make the application of violence redundant’.

But ethical considerations were only one reason why Richarz and Oebeke recommended this method. Moreover, rectal feeding cannot be seen merely in the light of the dispute between restrainers and non-restrainers. Griesinger, for instance, recommended the feeding tube, although he was a ‘non-restrainer’, whereas Damerow, never a ‘non-restrainer’, disliked the tube. So the relations between the ideal of ‘non-restraint’ and the introduction of a special technology were complex. Some, such as Richarz and Oebeke, advocated rectal feeding because they thought it helped to reduce violence, but others thought that using the tube was not at all violent.

Richarz and Oebeke were in a minority in their professional field, but they were neither heretics nor outsiders, and both were well accepted members of the profession. However, they had to act in a specific milieu – and this is a second reason why they were in search of alternatives to forced feeding. Richarz, after working at the Heilanstalt Sieburg in the Prussian province of the Rhineland, founded a private asylum in Endenich near Bonn in 1844 (Richarz, 1845). Oebeke, Richarz’s nephew, began to work there in 1859 and was head of this asylum from 1872 to 1889 (Pelman, 1914). Richarz’s attitude towards non-restraint and forced feeding was not only the result of
‘humanitarian’ ideals – he had to deal with a special clientele in his asylum for the better-off, with about 40 patients, and he had to earn his living from it. So middle-class attitudes towards restraint and violence had to be taken into consideration. Such people were often the first to ban violence in general and they wanted their relatives to be treated without harshness (Kaufmann, 1996), so it is understandable that Richarz searched for a milder treatment. Fortunately, ‘biological’ observations came to his aid. In 1869 he noticed that patients in public asylums, in contrast to his private patients, were ‘more resistant and of a less nervous disposition’ and therefore could bear forced feeding better than his patients whose feelings were not only more refined, but who were often fastidious and overprotected (Richarz, 1871: 213). Richarz and Oebeke had good reason to use a milder form of treatment.

Oebeke noted that, to date, ‘injections into the rectum’ were seen as only a curiosity, but now he had the ‘progress of chemistry’ on his side. Physiology and the establishment of modern theories of digestion, he believed, made feeding via the rectum a promising procedure. A method for converting albuminates into peptones had been discovered, therefore ‘digestion by the stomach was not required for the assimilation of these substances’ (Oebeke, 1871: 203, 209). Another argument was also involved: a specific physiological theory concerning the pathogenesis of sitophobia, developed by Richarz. In 1852 he had held that refusal of food was mostly due to the depressing effects of melancholia leading to the depression of the Nervus vagus which in turn resulted not only in a decreased desire for food but also in the inability of the intestines to ‘assimilate’ food. This explained why some patients fed with the stomach tube nevertheless lost weight and even died of starvation (Sammet, 2001). Therefore one had to look for other passages; another method was required to bypass the paralysed small intestine so that survival could be ensured while the N. vagus was depressed.

But could peptones actually help to feed patients? Oebeke (1871) only mentioned a short communication by Hermann Euleenberg (1814–1902) who had reported on their use in feeding weak patients at a general hospital and who had recommended it for the treatment of sitophobia in madness, though without mentioning rectal feeding (Euleenberg, 1861: 4). Oebeke and Richarz, in searching for a suitable composition for the liquid to be injected, conferred with the chemist Hans Heinrich Landolt (1831–1910). He proposed cold Liebig’s meat extract which was said to have a ‘high nutritional value’. This peptonized substance should be administered alternately pure and mixed with port wine, added ‘for vitalization and stimulation’ and which could perhaps lead to a ‘beneficial change in the activities of the nervous system’. Oebeke (1871: 204) believed his ‘meat extract peptone’ contained ‘all the nutritious constituents’ (except fat and fibre) ‘of lean meat’, including even the mineral nutriment. Therefore this extract seemed to him to be an ‘inestimable means’ which should be more widely used in psychiatry. Oebeke (1871: 205–9) then described ten cases in which he and Richarz had tried to
use this method, from around 1861.\(^8\) He reported convincing results. Death occurred in just one case: a 24-year-old woman died, but only because she had refused to be fed by clysters. For Oebeke, the refusal of rectal injections was the single important restriction of this method.

Oebeke (1871) only provided sparse information on the chemical and physiological fundamentals of rectal feeding, and Eulenberg, his 'warrantor' of the validity of the procedure, had not given any substantiated knowledge of the scientific background. This was not surprising because when Richarz first treated patients with rectal feeding at the beginning of the 1860s the understanding of all phenomena involved was rudimentary. But more information was not required then – the criterion of success was to preserve life. As only one person in ten had died, Oebeke inferred that saving the other patients was due to rectal feeding. For both of them the 'real' chemistry of peptones and the physiological principles of digestion in the rectum were only one element in their approach to dealing with sitophobia. Fifteen years later the 'progress of chemistry and physiology' had changed the picture.

In 1885 the question of the treatment of sitophobia appeared on the agenda of the annual meeting of the Verein deutscher Irrenärzte. The main speaker, Siemens, held that reduced food intake for the mentally ill as well as for the sane did not have 'as dangerous effects as generally' stated, and that 'an even longer period of complete nutritional abstinence can be tolerated within certain limits, usually without lasting effects' (Siemens, 1886: 459).\(^9\) Oebeke (1886), the second speaker on the subject, reacted to Siemens' views, and he also reviewed progress in the understanding of nutrition, hunger and the nutritional value of rectal feeding. To understand his views, it is necessary to describe briefly the findings of research in the physiology of nutrition up to the mid-1880s.

**Understanding peptones, digestion and the rectum**

There were two closely connected problems in nutritional medicine, especially regarding peptones.\(^10\) First, in order to treat patients unable to eat or drink, scientists tried to understand the digestive capabilities of the colon better. Was it possible to feed patients via the rectum? Was this anatomical structure able to absorb food and could rectal feeding therefore preserve life? Second, these deliberations were linked to the question of the physiological value of peptones - what role did they play in nutrition, if any?

An influential paper published in 1869 by Karl Voit (1831–1908) and Joseph Bauer dealt with the question of whether the 'secretions' of the colon could digest nutriments and, if so, could absorb these modified substances. Firstly, they found that the rectum was unable to absorb pure egg albumin, and it was only possible if common salt was added. Secondly, they saw that so-called 'acidalbuminats', i.e., proteins in acid solution (e.g., Liebig's 'meat
infusion’ or ‘meat juice’) were absorbed almost completely in the rectum, as were peptones which were produced from eggs, hydrochloric acid and pepsin. There was thus evidence that albuminous substances really could be used for rectal feeding. However, it seemed obvious that ‘it was not possible to keep alive’ a living being by means of clysters because, at best, only a quarter of the proteins required to sustain life could actually be substituted via the rectum (Voit and Bauer, 1869: 537, 538, 541, 543, 550, 553).

Notwithstanding Voit’s and Bauer’s researches, it remained somewhat arguable whether the absorption of nutriments in the rectum was successful enough to preserve life. Although Hermann Schreyer (1870) endorsed the opinion held by Voit and Bauer, he nevertheless noted that those who had used rectal feeding held ‘quite different views’, and ‘a definitive judgement’ seemed to be impossible. It remained undecided whether nutritional clysters were ‘useless’ or helped to prolong life (Schreyer, 1870: 16, 21, 25). Twenty years later, Otto Deiters, after doing experiments with two female patients, claimed that his special peptone preparation could substitute sufficient protein (Deiters, 1892: 18, 29).

However, most scientists held the view of Wilhelm Leube (1842–1922), one of the best experts at artificial feeding. In summarizing the research up to the turn of the century, he asserted that it was obvious that, considering ‘the restriction of intestinal villi on the small intestine, the capability of absorption of the colon is surely lower than that of the small intestine’, and therefore it was clear that there were ‘natural boundaries to the possibility of producing sufficient nourishment by artificial means’ (Leube, 1898: 496–7, 512).

But there was another problem to be solved. Already Voit and Bauer had contributed to the closely linked question of the nutritional value of peptones. Today peptones are defined as hydrolytic fission products of proteins containing a mixture of peptides and aminoacids. The fission is effected either by chemical acids, e.g., hydrochloric acid, or by ‘digestion’ by enzymes such as pepsin (Reallexikon, 1973: P83). Around 1900 the definition read slightly differently: a peptone was a ‘product which is formed from the protein of the food in the stomach under the influence of gastric juice and in the intestine under the influence of pancreatic juice’ (Munk, 1898: 412). The term itself was defined in 1850 by the chemist Karl Gotthelf Lehmann (1812–63). In 1867 Wilhelm Kühne (1837–1900) established the fact that there were not only peptones of the stomach but of the pancreas as well, and he added that stomach peptones were not uniform substances. Kühne found a second fraction of the fission which he called ‘albumose’ or propeptone. Lehmann had held that proteins had to be ‘peptonized’ to be subsequently absorbed; they were rebuilt into proteins and then contributed to the rebuilding of biological structures (Munk, 1898: esp. 412–13). A dictionary in 1891 said that all proteins had to be ‘peptonized’ before they were absorbable (Villaret, 1891: 475), but nevertheless this question was hotly disputed.

In contrast, Ernst Brücke (1819–92) not only saw peptones as useless
disintegration products which played no role in nutrition at all (Deiters, 1892: 3–5), but he also challenged the assertion that the ‘utilization of albuminats for the organism must be foregone by peptonization’ (Eichhorst, 1871: 570). At the end of the century the statement that albuminats had to be peptonized before they could be absorbed was refuted, and most scientists held that some proteins could be absorbed even in the rectum,23 but the question was not settled fully. Leube in 1898 remained sceptical as to the therapeutic use of unmodified proteins. He asserted that the rectum was indeed able to absorb those substances, but it was ‘a forced function’, not a natural one of the rectum. But for the organism it was of great ‘importance that nutriments introduced into the rectum for nutrition are capable of absorption as quickly as possible’ (Leube, 1898: 503).

So, around 1900, it was clear that, in principle, peptones were absorbable by the rectum, but it was also evident that they could not provide enough nutrients to preserve life. Moreover, there was another challenge endangering the method of Oebeke and Richarz. They had used clysters containing special ingredients, and to prepare their injections they used a quarter of a pound of beef, cut into little pieces, mixed with distilled water, some drops of hydrochloric acid and a little common salt; later, after a procedure of percolation, soluble pepsin was added, and, after a process of digestion, this solution was used for rectal feeding.23 But were these clysters really useful? From about 1850 Justus von Liebig (1803–73) publicized meat extracts as food, particularly for the poor. After mass production of Liebig’s meat extract started in Uruguay in the 1860s, a discussion began about the nutritional value of this product.24 Voit and Bauer (1869) held that it had no nutritive value at all; for example, they found only 1.15% of protein in it. Hermann Eichhorst endorsed the findings of Voit and Bauer (1869: 544, 545) and said that he had found ‘hardly’ any ‘traces of proteins’ in the meat extract he had examined (Eichhorst, 1871: 655). The controversy continued for some decades, but around 1900 most scientists believed meat extract to have no nutritive value at all, although it should have stimulatory effects on the nervous system. Thus, Georg Klemperer (1865–1946) remarked that its ‘excitant effect on the entire nervous system can be guaranteed’ which therefore ‘contributes considerably to the refreshment and recovery of weakened individuals and subsequently to the achievement of a better alimentation’ (Klemperer, 1898: 287).

So obviously ‘rectal feeding’ in general and Richarz’ and Oebeke’s peptone method in particular seemed to be a complete failure – at least when compared with their intentions. Trying to feed and keep alive patients in that way was impossible. But Oebeke (1885), having summarized the findings of the physiologists (and in doing so, showing that he was a bit more cautious as to the value of rectal feeding), noted that a human being was no ‘arithmetical problem’, and it was impossible to calculate exactly ‘how long anyone can survive without food and drink in a given case’ (Oebeke, 1885: 689). All the
proposed normal values were not in accordance with his experience. For example, some asserted that nutritional abstinence could be tolerated for fifty days (if the patient took in water) or fourteen days (without water). It was also claimed that a human being could sustain the loss of 40% of his body weight. To Oebeke all these figures went against the dogma of individualization. The results available at this time were too ambiguous, and many questions were still unsolved. Oebeke was not an obstinate ‘practitioner’ who withdrew from scientific progress, and his greater caution and restraint about rectal feeding had much to do with the latest physiological findings which challenged the Endenich approach. But his experience and practical knowledge after a long career as an alienist made him sceptical about laboratory results.

In restating Voit’s and Bauer’s assertion that it was impossible to ‘feed a human being adequately over a longer stretch of time’, Oebeke (1886: 473-4) said that this was ‘difficult to prove’. Laboratory results were not necessarily a yardstick for daily life. He added that other investigators had examined the absorption of other substances in the rectum, e.g. sugar, fat, which could help to maintain nutrition, so the Endenich approach could not be discarded outright, even if scientific findings were considered. Overall, he was very convinced in his judgement:

How long a human being can be kept alive if this procedure is followed exclusively cannot be said up to now, because the great advantage which could be achieved hitherto lies in the fact that the nutrition does not decline so rapidly and intensively and that perhaps the patients begin in the meantime to take food again. (Oebeke, 1886: 471)

So the most obvious success of rectal feeding was a ‘gain of time’. The advantages of this method had to be seen as a ‘longer preservation of life, a prophylactic measure before the voluntary taking of food and the avoidance of any kind of restraint’ (Oebeke, 1886: 469-70).

But even if scientific knowledge became accepted, solving the problem of sitophobia required more than implementing an isolated procedure more or less automatically. Alienists had to consider the ethical issues and the theoretical presumptions (such as Richarz’ theory of the pathogenesis of sitophobia). Other factors to deal with were the resistance of the patient; the anatomy of the digestive tract; the problem of the stiff and dangerous tubes; and the procedural instructions for the attendants and alienists about stepping up intervention if necessary. All this made up a complex ‘actant’ or method which then in turn had to be tested in the reality of an asylum.

Conclusion

Rectal feeding was neither a failure nor a success. Many textbooks mentioned it as the middle step in a plan of escalation of treatment. This ‘technology’ was only an episode in the history of psychiatry, and it was not a common
practice in all German asylums, but it should not be seen as having merely marginal importance. However, as more and more unsatisfactory results were obtained, its use decreased. What is more interesting is the fact that the simple action of putting a nutritional clyster into the rectum was part of a complex web of practices, deliberations, different medical theories, ethical considerations and experience; the physiology of nutrition, anatomy and the manufacture of peptones worked with and against socially/technically skilled attendants and alienists, who were instructed in the correct handling of sitophobists. Alienists hoped to avoid violence by employing different ‘techniques’ – although sometimes these failed. So, even when there was no alternative to the gastric tube, when the treatment of sitophobia was ‘black boxed’, when it was made ‘durable’, the complexity of the problem remained: the ‘machines’ could not work efficiently because of the ‘duration’ and obstinacy of sitophobia itself.

Notes

1. The term sitophobia originates from the Greek sitos meaning wheat, cereals or bread and, derived from that, food or aliment. So sitophobia means a morbid fear of food.
3. All translations have been made by the author.
4. This article is limited to German psychiatry, but when German authors mention foreign contributions to the field, I will cover them briefly. There were probably different national attitudes to dealing with food refusal by the mentally ill. It appears that in France the use of ‘instruments’ such as the sonde oesophagienne was quite widely accepted, but that German psychiatrists tended to a more sceptical position around 1850, as discussed below in the text. This question deserves further research which should address various issues: Were there different cultures of asylumdom and, if so, how did these influence the use of violence and specific technologies? Were there different positions on the ideal of ‘non restraint’? Wider perspectives should also be considered, for example: did attitudes to day-to-day violence in general differ in France and Germany, and did these views, in turn, have effects on the discourse in psychiatry?
5. This paper focuses on the alienists’ discourse on treating refusal of food. It will be outlined in the text below how the integration of rectal feeding in the everyday therapeutic regimen of ‘sitophobists’ was often a complex challenge. Further research, e.g., using case records from different asylums, is certainly needed to see whether there were differences between theory and practice.
7. This paper is only a part of a project on the history of sitophobia in German psychiatry during the nineteenth century. It is also a short contribution to the question of technologies in the history of psychiatry. Here I restrict myself essentially to the question of a specific therapy. In order to understand fully what sitophobia meant, further research is needed, e.g., on the discourse about its aetiology and pathogenesis. Why and how
forced feeding with the gastric tube established itself as the most important technology also deserves examination. In the present context I can only report that it was widely accepted. Moreover, research on other techniques developed since the 1860s/70s must be done to understand better the role that ‘technical solutions’ played in psychiatry. In particular, the introduction of drug therapy and the use of syringes (e.g., for subcutaneous feeding) should be examined (on psychopharmacology as a ‘representative of “technical” strategies of problem-solving’, see Weber, 1999, especially 177–8; and on the history of the development of subcutaneous syringes, see Schramm, 1987).


10. Lachr was reporting on the instrument invented by J. F. B. Charrière (1803–76), who was assigned the task by L.-A.-E. Billod (1818–86), head of the French asylum in Blois. See the description and an illustration in Anonymous, 1850.

11. Verga’s article had originally been published in an Italian periodical, but later it was translated into French and edited as part of a discussion in Annales medico-psychologiques.

12. On the complex history of ‘gastric tubes’ which were used for different purposes, see Korsch (1971), who reviews the literature particularly up to the first third of the nineteenth century. He makes clear that these apparatuses were often applied in desperate cases of, e.g., obstructions of the oesophagus or dysphagia, and were then constructed ‘spontaneously’ without using them as instruments of daily routine. Around 1880 the scene changed. W. Leube, in one of the first monographs on the history of the stomach probe, mentioned that around ‘three decades [ago], two main sorts of gastric tubes were established: those made of hard rubber and the English probes’; the former were ‘very elastic’, the latter were harder, but use of either could result in injuries of the oesophagus or even the stomach (Leube, 1879: 22–3). So, although there had been standardization, the technology of the instruments was not ‘stabilized’ up to that time.

13. The notions of ‘organism’ and ‘machine’ are not always opposed to one another. In fact the notion of ‘machine’ is more complex. On the history of this concept in philosophy, see Schmidt-Büggemann, 1980.

14. Healing is possible ‘only in a new, purpose-built asylum’ and only when all requirements are fulfilled; Roller, 1831: ix.

15. Even today, the remark made by Nancy Tomes (1988: 218, n.6) is still true: that ‘(t)here is surprisingly little written on the non-restraint movement’. This particularly applies to the history of German psychiatry (where there is only one study on the discussion of non-restraint in German-speaking countries, and that is not really convincing; Geduldig, 1975). For the British case, see, for instance, Scull, 1983/4 (a brilliant study on the founder of non-restraint), and Suzuki, 1995. Meyer should have been the first to implement non-restraint in a German asylum (in Hamburg): see Meyer, 1863: 575–9; 1897. There is also an instructive discussion of the (probable) fact that non-restraint was actually only implemented ‘rhetorically’ in Germany (Anonymous, 1880).

16. Interestingly, the introduction of drugs in therapy was accompanied by discussions on its influence on violence or reduction of violence. Again, we find different attitudes to this: whereas some thought drugs should be seen as using a ‘chemical straitjacket’ and a means of disciplining the insane, others held that medicaments helped to calm violent inmates of asylums and were therefore an essential part of the introduction of ‘non-restraint’ (see Weber, 1999: 85).
17. At the start of 1865, the asylum had 36 patients living there; at the start of 1873 there were 41 (Oebeke, 1875).
18. Unfortunately patient records of the Endenich asylum could not be found. I am much indebted to Volker Roelcke, Giessen, and Lisa Orth, Bonn, who helped me to contact Wolfgang Schaffer, whose generous help I much appreciate. Dr Schaffer of the Rheinisches Archiv- und Museumsamt, where some primary sources of this asylum are deposited, told me that there are no case records extant.
19. Siemens had already expressed this opinion earlier (Siemens, 1883); see also the reviews on his point of view by: Schüle, 1885; Stark, 1885. Siemens (1884: 416) added a case study about a patient affected by paranoia to emphasize his approach; although this patient was finally fed by the probe, Siemens used the case to illustrate that alimentary abstinence could be tolerated longer than previously thought.
20. My outline of the discussion about digestion and nutrition in nineteenth-century physiology is very simplified, and my account of the history of peptones is schematic; for the history of the physiology of nutrition and proteins in general, see: Carpenter, 1994; Mani, 1976.
21. Leube was one of the first to use so-called ‘meat pancreas clysters’ around 1870 – a method which was adopted by some alienists; see, for instance, the restrained optimism in the note of Arthur von Gellhorn, 1874: 341.
22. The detailed studies by Eichhorst (1871: 618, 646, 652) showed – as already stated by Voit and Bauer – that egg albumin was absorbed only when common salt was added, and that undissolved fibrin of the blood as well as proteins of the blood serum could not be absorbed, whereas myosin and some sorts of alkali albuminates were reabsorbed.
23. The composition was never modified from that used early on; Oebeke, 1871: 205; 1885: 695; 1886: 470.
24. For a detailed account of this discussion about meat extract and meat broth, see Teuteberg, 1990: 9–37.

References


Leidesdorf, Max (1865) Lehrbuch der psychischen Krankheiten, 2nd edn (Erlangen: Ferdinand Enke).


Leuret [François] (1845) Note sur une sonde destinée à l'alimentation des aliénés. Archives générales de Médecine, 9, 220–2.


Oebeke, Bernhard (1871) Zur Behandlung der Nahrungsverweigerung bei Irren ohne


