understanding of madness was the notion of ‘responsibility’. With the regaining of their humanity the mad were also granted the right to responsibility for their actions.10

In 1813, Samuel Tuke published his famous Description of The Retreat. In it he admitted that the ‘principle of fear, which is rarely decreased by insanity, is considered as of great importance in the management of patients’. He added however, that ‘it is not allowed to be excited, beyond that degree which naturally arises from the regulations of the family’, because, he believed, there ‘cannot be a doubt that the principle of fear ... has a salutary effect’. 11 In 1841, a Statistical Report of the Retreat prepared by John Thurman 12 defended the use of fear, claiming that it was the inevitable companion to hope, and that the fear of the loss of privileges, would be of ultimate benefit to the patient:

the feeling of hope, almost necessarily implies that of its opposite, fear, and it is no doubt true that on the one hand the hope of acquiring, and on the other the fear of losing those greater degree of liberty and comforts which are granted upon the appearance of amendment have a beneficial action and reaction, both on the patient as a body, and even on the same individual.13

If De la Rive and Thurman were equivocal in their praise of the new methods of treatment Foucault is both colourful and condemnatory in his more recent portrayal of them. ‘Tuke created an asylum’ he claims ‘where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience’.14

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10 Two years after the Retreat opened it was visited by Dr. De la Rive of Geneva who wrote a long letter to the editors of the Bibliothèque Britannique describing what he had seen there, and articulating his views on the moral part of the treatment of the insane’ as practised therein. He claimed: You see that in the moral treatment, they do not consider the patients as absolutely deprived of reason, that is to say, as inaccessible to the emotions of fear, hope, sentiment and honour. They consider them, rather it seems as children who have a superfluity of strength and who would make dangerous use of it. Their punishment and rewards must be immediate.[ Source: A. Walk, ‘Some Aspects of Moral Treatment of the Insane up to 1854,’ The Journal of Mental Science (JMS), vol.100, no.421, (October 1954), p.817].

11 Tuke, Description of the Retreat, pp.141-42.

12 The Act for The Regulation of the Care and Treatment of Lunatics was passed in 1845 and required the resident superintendent of an asylum to be a medical man. The first such qualified medical man to hold the position at the ‘Retreat’ was Dr. John Thurman.


14 Foucault, Madness and Civilisation, p.247.
Moral Treatment and Optimism in the Colonies

The medical profession's attitude towards insanity was characterised by an almost unprecedented optimism from about the 1840s until the 1870s. This confidence was not entirely without foundation. The successes of the early decades of the century in curing and preventing physical diseases initiated the widespread belief that diseases of the mind would shortly also yield before the power of scientific techniques. These achievements seemed to provide the proof for the belief in the ultimate infallibility of science, as medical science in particular, seemed poised on the brink of total understanding. The apogee of this belief in medico-scientific explanations was contemporaneous with the establishment of asylums in the Australian colonies. This meant that the Australian asylum system had no need even to reject previous notions of insanity, but was born into, and through the auspices of the scientific era. Moreover, the elite of a colonial society was anxious to re-create some sort of a class system that they could understand. For this reason it seemed particularly amenable to the notion that a specific occupational group possessed a scientifically based expertise in dealing with lunacy.

The Kew Asylum, high on its hill in suburban Melbourne was a direct descendent of the ideas and doctrine pioneered by Samuel Tuke. The sweeping vistas and the plans for beautiful gardens emerged from the same philosophy that Tuke had implemented at York 100 years earlier. During the intervening years however, notions about insanity had not remained static. Rather, they were continually supplemented and reinterpreted through contemporary doctrine and by contemporary commentators. Notions of 'morality' became even more entrenched. The 'triple cornerstones of Victorian psychiatric theory and practice were moral insanity, moral management, and moral architecture'.\(^{15}\) Moral management or moral treatment was the most important of these and was consistently seen as synonymous with kind or humane treatment. During the mid nineteenth century, it increasingly began to be represented specifically as treatment opposed to coercion, in particular the

\(^{15}\) Showalter, Female Malady, p.29.
coercion of ‘mechanical restraint.’ Largely because of the work of English alienist John Conolly, Victorian England came to be seen as the centre of lunacy reform.\textsuperscript{16}

The Journal of Mental Science, claimed in 1873 that:

the year 1840 was contemporary with a grand revolution in the treatment of the insane in England. In the year 1839 Dr. Conolly [Superintendent of both Hanwell and Colney Hatch asylums], following Pinel, Esquirol and our countrymen, Tuke and Charlesworth, had published his first yearly report. In 1840 he could tell the world that there had not been one single instance of mechanical restraint at Hanwell through the preceding year.\textsuperscript{17}

Regardless of the doubts which have been articulated about moral management, it is fair to say that ‘from the 1830s to about 1870, experiments in the humane management of madness put English psychiatry in the avant-garde of Western medical practice and made English lunatic asylums a mecca for doctors and social investigators from all over the world’.\textsuperscript{18} Certainly, members of the British Medico-Psychological Association cast themselves in an evangelical role as ‘men of acute intellect and compassionate hearts [who] applied themselves ... to teach that better way which has since been invariably followed’.\textsuperscript{19}

For this reason, as much as a sentimental attachment to British institutions, the medical staff of asylums in colonial Victoria looked primarily to prominent British alienists for their hypotheses on which to base the administration of their own institutions. Besides Conolly, they were particularly

\textsuperscript{16} John Conolly (1794-1866) was the famous mid-century alienist who was superintendent of both Hanwell and Colney Hatch asylums. He is credited with being the overseer of the first asylum to abolish mechanical restraint. Colney Hatch opened in 1851, and was considered the showcase of Victorian Psychiatric reform. Elaine Showalter describes it as the ‘largest, most modern, and costly asylum in England ... it had a spectacular Italianate facade nearly a third of a mile long, with campaniles, cupolas, stone rustic quoins, cornices, and ornamental trimmings ... it was a wonder of modernity ... and the model institution from which European psychiatry would take its pattern (Showalter, Female Malady, p.23-24) It was also the institution from which the designers of Kew asylum largely drew their inspiration. Conolly’s most famous written works were The Construction and Government of Lunatic Asylums published in 1847 and Treatment of the Insane without Mechanical Restraint published in 1856.

\textsuperscript{17} T. Harrington Tuke, ‘The President’s Address of the Medico Medico-Psychological Association’ JMS, vol.xix, no.87 (October 1873), p.328.

\textsuperscript{18} Showalter, Female Malady, p.25.

\textsuperscript{19} Harrington Tuke, ‘The President’s Address for 1873’ JMS, vol.xix, no.87 (October 1873), p.330.
influenced by the ideas and writing of contemporary British doctors like Henry Maudsley, G. Fielding Blandford, and Daniel Hack Tuke the great grandson of Samuel Tuke. All of these men were eminent members of the British medical profession during the time in which Australian asylum administrators were formulating their early policies. 20

The Theory of Degeneration

Although the rhetoric on asylum treatment emphasised the ‘power of gentleness and kindness’ which alienists held as implicit in the non-restraint system towards those ‘who in the old times, were treated as the outcasts of humanity’, 21 there existed, nonetheless, an underlying assumption about the insane themselves. In The Order of Things Foucault identifies ‘a positive unconscious [emphasis in original] of knowledge; a level that eludes the consciousness of the scientist and yet is part of scientific discourse’. 22 Within the medico-psychiatric discourse of the mid and late nineteenth century this ‘positive unconscious’ was constructed around the notion of degeneration. 23 Essentially a part of

20 Henry Maudsley was possibly the most well known of the British alienists. He wrote many works on insanity, two of the most well known were Body and Will published in 1883 and Pathology of Mind published in 1895. He was, from 1862-1878, joint editor of the British medical journal concerned only with mental illness, the Journal of Mental Science, and president of the Medico-Psychological Association in 1871. In 1866 he married Ann Conolly the daughter of the prominent early Victorian alienist John Conolly. They had no children.

Daniel Hack Tuke was born in York in 1827. He was the youngest son of Samuel Tuke (grandson of Samuel Tuke founder of the York retreat.) He was the first of the family to formally enter the medical profession and continued the family tradition of involvement with the Retreat as he held the position of visiting physician. For many years he held a firm belief in Phrenology and he made a long and continued study of it. Although, according to The JMS he ‘made a number of observations [JMS, vol.xli, no.172, January 1895, p.379] he eventually was to lose faith in the 'science'. He was also for a number of years co-editor of the JMS. His work which he co-wrote with Sir John C. Bucknill entitled A Manual of Psychological Medicine, in 1858, and which reached a fourth edition by 1879 was, according to Hunter and Macalpine ‘the first of the modern textbooks’.(Source: R. Hunter and I. Macalpine, Three Hundred Years of Psychiatry, Oxford University Press, Oxford,1963, p.1069.) He had a number of other publications including History of the Insane in The British Isles, published in 1882, and his last major publication Reform in the Treatment of the Insane published in 1892. He died in 1895. On his life and work see G. Zilboorg The History of Medical Psychology, pp.422-31.

G.Fielding Blandford M.D. was a lecturer on Psychological medicine at the school of St. George’s Hospital London. His treatise Insanity and its Treatments; Lectures on the Treatment Medical and Legal of Insane Patients was first published in 1871. (See Chapter Three, ‘Breaching The Walls’, for additional information.).


23 Degeneration was not a theory exclusive to the Victorian age, but ideas that humankind has declined and decayed from some former Golden Age or paradisical state have pervaded culture, literature and science ever since Biblical and Greek times. Modern scientific ideas of degeneration take their intellectual
Victorian social commentary based on a Darwinian theory of evolutionary regression, degeneration became the major premise of insanity philosophy. As Daniel Pick explains:

Degeneration slides over from a description of disease or degradation as such, to become a kind of self-reproducing pathological process—a causal agent in the blood, the body and the race—which engendered a cycle of historical and social decline ... Degeneration was increasingly seen by medical writers not as the social condition of the poor, ... not the effect, but the cause of crime, destitution and disease. 24

Degeneration for the medical profession thus became understood and translated as an 'hereditary taint'. As such it was held to be present as an underlying factor in the majority of cases of insanity. Henry Maudsley was the most prominent member of the British medical profession to explicitly refer to degeneration. The *Australian Medical Journal* noted with reference to the case history of J.F. Lawrence, a convicted homicidal maniac, quoting directly from Maudsley, 'it is where the hereditary taint exists that we meet with the most striking examples of this kind of derangement'. 25 And in a later edition, 'parents who are mentally or physically diseased will have children with the same or any other form of the same disease'. 26 Maudsley and Blandford even castigated Dr. Skae,27 Superintendent of the Royal Edinburgh Asylum, who, they claimed, failed to stress the 'hereditary factor' enough in an address in 1873. Skae explained that he had 'no occasion to speak of hereditary

ancestry from these roots' (Source: Bullock A. Stallybrass O., Trombley S.,(eds) *The Fontana Dictionary of Modern Thought, 2nd edition*, Fontana Press, London, 1990, p.209.) Nevertheless, supported by Darwinian evolutionary theory these ideas assumed a new significance during the nineteenth century. Central to modern degenerationism were medical notions of the progressive manifestation of inherited physical and mental defect, advanced in particular by the French psychiatrist B.A. Morel, and taken up by other aliens such as Maudsley.

25 Editorial, 'Impulsive Insanity and the Convict Lawrence', *AMJ*, vol.i, new series, no.10 (October 1879), p.489.
27 Scottish Physician David Skae, Superintendent of Edinburgh Asylum, was probably the first person to maintain that there was a particular and specific type of insanity due to masturbation. In his paper of 1863, Skae lays down the principle that mental disorders should be classified according to their natural history rather than by their associated symptoms. [Source: *JMS*, vol.108, no.452 (January 1962), p.6.]

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taint at all’, because he had concluded that it was ‘neither a pathological nor exciting cause of insanity, it is a predisposition to the disease ... there must be a predisposition in almost every case of insanity.\footnote{D. Skae & T.S. Clouston, ‘The Morisonian Lectures on Insanity for 1873’, JMS, vol.xix, no.87 (October 1873), p.351.}

This exchange seemed to indicate that hereditary factors had become so universally accepted as a facet of insanity the only debate which appeared legitimate was the extent to which it was implicated or the manner in which it was manifested in particular cases. A variation suggested by Maudsley for example, claimed that the ‘son of an epileptic may be more likely to become insane than the son of a person who has been actually insane’ or that ‘nervous disease in the parent may manifest itself in the offspring in the form of a tendency to insanity’.\footnote{H. Maudsley, ‘Insanity and its Treatment’ JMS, vol.xvii, no.79, (October 1871), p.315.} Utilising these theories, the Australian Medical Journal concluded in its editorial on the convict J.F. Lawrence:

> As to hereditament [sic]-on his father’s side, his grandmother, an uncle, an aunt, and two first cousins were insane: a brother last year suffered from fits of despondency ... moping, crying, unable to attend to business.\footnote{Impulsive Insanity and the Convict, Lawrence,’ AMJ, vol.i, new series, no.10, (October 1879), p.489.}

In addition, within a more explicitly Lamarckian\footnote{The views held by the French zoologist Jean Baptiste Pierre Antoine de Monet le Chevalier de Lamarck (1744-1829) are inadequately summarised as that of the ‘inheritance of acquired characteristics’. In Darwin the heritable variations that are the subject of natural selection arise either spontaneously or not at all. [Source: Bullock et al,The Fontana Dictionary, pp.462-63.] Maudsley explained his sympathy with Lamarck; ‘character’, he wrote, ‘grows by adaption and gradual accumulation of increments through the ages’[quoted in Pick, Faces, p.208.]} discourse they also claimed:

> His father, when in the Peruvian army, about 1828 (anterior to his marriage), was shot in the head and trepanned: after which, slight irritation is said to have deprived him of all self-control’.\footnote{Impulsive Insanity and The Convict Lawrence’, AMJ, vol.i, new series, no.10, (October 1879), p.491.}

Maudsley was so strongly influenced by Darwin’s evolutionary theories, that initially, if somewhat paradoxically, he portrayed degeneration as a positive force in society — proof that society was...
indeed advancing. As he was to assert confidently in 1860, 'humanity in its progress upwards, fashions the supporting stem only by sacrificing the early branches' 33. Thus, the 'mad' were among the sacrificial castoffs of society, evidence of the continuing and robust advance of civilisation whose increasingly high standards they could not hope to fulfil. In addition, the nature of degeneration was originally thought to guarantee its own demise, as its progress through a few generations of one family would inevitability result in sterility. 34 While it is not clear how or why this should happen, a suggestion of sorts was offered by Skae in 1873. In a long article with its emphasis on the profligate nature of those afflicted with lunacy, Skae introduced the concept of the 'hereditary insanity of adolescence'. It was, he claimed:

A very distinct form of insanity that we often meet with in the members of families strongly tainted with neurotic inheritance, at about the age of twenty, or from eighteen to twenty-five, just as the patient is coming to maturity ... It is the purest type of hereditary insanity ... It is a sort of dotage of the brain. They have thus died to all the passions, the cares and human interests that occupy other men. It is an example of Nature's mode of stopping the reproduction of disease.35

Skae concluded: 'However hard on the individual it is certainly good for the race. I have thought it a good sign for the others if one of a family was thus affected. He was the scapegoat for the rest.' 36

This optimism in the natural and gradual elimination of madness, was adopted as part of early philosophy about lunacy in Victoria. As a relatively 'new' society the 'Australian colonies came into

33 Quoted in Pick, Faces, p.203.
34 Morel's theory of degeneration insists that, 'Les degenerations sont des deviations maladies du type normal de l'humanite, hereditairement transmissibles et evoluant progressivement vers de la deceance.' (Degenerations are deviations from the normal human type, which are transmissible by hereditary, and which deteriorate progressively towards extinction', (Source: E.H.Ackerknecht, A Short History of Psychiatry, Hafner Publishing Company, London, 1959, p.48.)
36 ibid.
being as an enclosed and knowable population’, 37 therefore were seen as an especially appropriate environment for the observation of the eradication, or at least containment of insanity. An article in the annual report of 1872 best summarised this attitude:

The colony was established chiefly by the influx of healthy adults, only a small number of insane persons were landed amongst the immigrants, the insane members belonging to the generation left behind. In its infancy the colony enjoyed an almost complete immunity from a burden which hangs on every civilised community. But, after a while insanity commenced to develop itself in those liable to its attack ... As the insanity latent in the immigration population becomes, so to speak, worked out, this process of increase slackens and should reach its natural limit at the expiry of a generation. 38

Doctors who held dear these notions about the ‘natural working out ‘ of insanity in the population by the early demise of afflicted individuals, must have felt vindicated by, if not entirely unsympathetic to, incidents like the tragic case of the McLaren family. Brothers William and John McLaren were admitted to Kew on the same day in October 1879, classified as suffering from imbecility and idiocy respectively. At the time, William was 13 and John just nine. Their case notes show a marked similarity, both suffered frequent epileptic attacks and both were constantly in feeble health. It was also noted that William was ‘inclined to kick and bite’, and John was ‘occasionally noisy’. William remained at Kew until he developed ‘symptoms of lung disease’ from which he died in 1887, after being in ‘failing health for some years’. John too, succumbed to his illness at the age of 21 in June 1891 after having been ‘confined to bed for some years’ and ‘slowly dying’ since April of the preceding year. 39 The case notes reveal little about the parents of the boys, apart from the fact that they were frequent visitors to the asylum.

37 See L. Finch, *The Classing Gaze: Sexuality, Class and Surveillance*, Allen and Unwin,Sydney, 1993, for a discussion of how this operated in the construction and recognition of a ‘respectable working class’ in Australia. In the same manner the underside of this-the ‘unrespectable’ class or the deviants of society were also more easily observed.


39 PROV, VPRS, 7398 /P1, Unit 7, p.64.[William] Unit 7, p.65.[John].
Treatments and Cures in the 1870s

‘New’ Drugs and Humoral Therapy

Alongside the rhetoric that prophesied the decrease in insanity through a natural evolutionary process ran a counter argument that suggested that it was active scientific intervention represented by new drugs that would alleviate the problems of madness. The two theories were not seen as conflictual, however, as the insane were divided by the medical staff into two major classifications—the curable and the incurable. Presumably the incurable could only be eliminated by ‘breeding out’ before they had a chance to procreate, in the manner of the McLaren boys, and as suggested by Dr. Skae. The ‘curable’ would benefit by asylum treatment. Superintendents often requested that only those ‘capable of cure’ remain in the asylum as ‘the special aim of the physician is to heal disease, not merely to care for the incurable’. 40 Moreover, in Australian asylums in particular the incurable were seen as a hindrance to the curative process, and the cause of the overcrowding. As Dr. Robertson commented in 1872:

In other countries it is workhouses, and not what are supposed to be hospitals for the curable insane, that are recognised as the places for such persons ... the present asylum accommodation would, if the imbecile class were removed, in all probability, be sufficient for some years to come, for the curable, destructive, dangerous and suicidal which are the only cases suitable for asylum treatment’. 41

‘It is a well established fact,’ claimed the Australian Medical Journal in 1873, ‘that 70 if not 80 per cent of cases of insanity admit of easy and speedy cure if treated in the early stage ... recoveries in the early stages are as four to one, in the later stages as one to four.’ 42 Thus ‘curable insanity’ was diagnosed if the symptoms of madness were seen to be of recent duration. This was problematic at

best, because, as noted before, relatives were often reluctant to admit patients until they became violent or otherwise uncontrollable.

But the greatest problem was that the doctor’s claim to expertise was shown to have had little basis when it came to any sort of effective treatment. This was in spite of the confident assertion in 1873 by the Journal of Mental Science that during the last ten years ‘many drugs have been added to the pharmacopoeia, and the experience of every year adds to our knowledge of their efficacy’. But certainly, some medications alleviated patient’s physical illnesses but more often they simply modified immediate problems of behaviour or induced sleep. Most of the drugs used were sedatives, hypnotics or laxatives. Doctors in colonial Australia were quick to adopt new drugs at this time, as testified by the article on Hydrate of Chloral in 1870 in the Australian Medical Journal. This ‘new remedial agent’ claimed the article was ‘at present exciting so much interest in the medical world, both at home and abroad’ and would ‘take a permanent place in medicine, and rank with the most useful ... discoveries of modern science’. The following year, the British Journal of Mental Science also alluded to ‘the new drug chloral hydrate’ and also concluded:

It claims the foremost place as regards the remedial value of medicines used. In the majority of cases, it may be relied upon to produce sleep, and that without causing disorder of the digestive organs or other unsatisfactory results.

Chloral hydrate was a powerful sedative and became one of the most used drugs at the Kew asylum. It was either used alone, or in conjunction with other drugs, potassium bromide, laudanum, morphine or even opium being among the most popular. Brandy was often included as an additional medicinal treatment.

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45 Dr. Macintosh, 'Hydrate of Chloral' JMS, vol.xvii, no.79, (July 1871), p.239.
A notorious incident involving indiscriminate drug use at Kew concerned the case that instigated the Inquiry in 1876. This was the sudden and unexpected death of Leon Lewis. Lewis, a tobacconist from Sandhurst, was admitted on 17 December 1875, suffering from 'mania'. Because he was 'very noisy' and persisted 'in taking his clothes off' on 25 December he was given two large doses of chloral hydrate during the night. During the next few days, he was also given other sedatives including more chloral and potassium, as well as brandy. He was also put in a camisole. On December 29, he underwent an operation to correct a suspected broken tibia, for which he was given chloroform. After the operation, he was injected with almost a whole gram of morphine whereupon he fell into a deep sleep, and died at five o'clock the following morning. Prior to his admission, Lewis had seen 'a medical man who gave him some bromide of potassium and ... another who ordered a mixture containing strychnine, phosphorous and iron.' In spite of what appeared to be overwhelming evidence of too liberal drug use, the Inquiry found that Lewis died 'from inflammation of the brain, not morphine poisoning'.

Copious amounts of laxatives such as cod liver oil or castor oil were administered together with the dreaded croton oil, known to the patients as 'sugar on a spoon', as it generally had sugar added to it to help alleviate the bitterness. Laxatives were dispensed not only for simple constipation, but also as a purgative. In spite of the emphasis on the new and 'scientific drugs', members of the medical profession were still operating largely within notions of humoral theory. Dr. Blandford's treatise on Insanity and its Treatments revealed the strong attachment to humoral therapy that still informed any treatment of the insane. In it he explained the need for 'healthy blood supplying the waste in the brain cells', that was 'rich in oxygen ..and free from all impurities, as urea, bile, carbonic acid, or other poisons'. In addition, he added, 'secondly, we require for the due discharge of mental action a certain amount of heat.'

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46 PROV, VPRS 7398/P1 Unit 4, p.34. Also see Kew Inquiry, VPP 1876, vol.3, pp.6,7,11 and 63.
Besides purgatives, blistering, poultices⁴⁸ and even leeches were sometimes used. Leon Lewis for example, besides being given all the medication mentioned, first had his ‘head shaved and blistered’⁴⁹ As was explained at the Inquiry by Dr. Robertson, ‘It was a very common thing in the case of acute mania to have the head shaved and blistered’⁵⁰ The purpose of this was to ‘relieve the pressure on the brain’, a routine form of humoral therapy. William the elder and more excitable of the two McLaren boys, was also subjected to this form of treatment after his epileptic attacks became more frequent.⁵¹

Blistering was also used to alleviate physical symptoms, as demonstrated by the case of Catherine Frawley. Catherine, a nurse of ‘regular habits’, was diagnosed as ‘melancholic’, when she was admitted in February 1875. She underwent treatment by ‘blistering’ of her stomach. She was given ‘acid mist’, a modified form of chloral hydrate, and her stomach was pumped when she showed signs of gastric disorder. Not altogether surprisingly, on 27 June she still appeared ‘very melancholic’, and complained of pains in her side. For 12 months, Catherine was treated with doses of cod liver oil and chloral hydrate. When she occasionally resisted, the drugs were administered by force. Whether due to the treatment, or, more likely as testament to the strength of her constitution, a later but undated entry in Frawley’s case notes described her as ‘in excellent health’. Unfortunately, it appears she did not recover sufficiently to be discharged, as she was ‘transferred to Ballarat [asylum] on 7 May 1878’⁵².

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⁴⁸ A blister was similar to a poultice except it was applied with the specific aim of creating a blister on the skin. It is described in Black’s Medical Dictionary as a process employed ‘in cases of both acute and chronic inflammation, on the principle that irritation of the skin causes congestion of the part immediately below the skin, while it relieves congestion of deep-seated organs [in the case of the insane, the brain] through an action upon the nerves that regulate the size of the minute blood vessels. Substances employed ... are rubefacients, or substances which merely redden the skin and cause it to peel off; and vesicants, or blistering applications; when in addition, they produce a collection of fluid under the skin...The chief rubefacients are; mustard, turpentine, liniments of ammonia, chloroform etc. and of vesicants cantharides or Spanish fly, pure acetic acid, ammonia and chloroform ...’ [At Kew the most common blistering agents used were probably mustard and/or chloroform.] Mustard is made into a paste and spread on muslin or brown paper, and applied directly to the skin for twenty or thirty minutes until a warm glow is felt... Acetic acid, ammonia, and chloroform are used by soaking a piece of lint of the required size in one of these fluids, applying it, and covering it with a watch-glass till the blister rises.’ (Source: C. Havard (ed), Black’s Medical Dictionary, 36th edition, A and C.Black, London, 1974 (1st edition1906), pp.112-13).

⁴⁹ PROV, VPRS 7398/P1, Unit 4, p.34.

⁵⁰ Kew Inquiry 1876, p.36.

⁵¹ PROV, VPRS 7398/P1, Unit 7, p.64.

⁵² PROV, VPRS 7397/P1 Unit 3, p.1.
Although much humoral therapy appeared quite punitive by its very nature, there were times when the therapeutic treatments were even more difficult to distinguish from deliberate attempts at punishment. This has been described as the 'conversion of medicine into justice, of therapeutics into repression'.\(^{53}\) One of the most popular methods of dispensing this form of 'justice' was through water treatment. Baths and showers had long been used within notions of humoral therapy, supposedly to cool or refresh the nervous system. The *Journal of Mental Science* in 1873 urged that doctors not neglect water treatment as one of the earliest forms of 'medical treatment'.\(^{54}\)

Another article made the astonishing claim that 'the use of cold water applied to the human body in the form and much after the same fashion as that in which nature finds it most beneficial to the vegetable kingdom [would] promote or aid the recovery of patients.'\(^{55}\) It is clear that this particular form of treatment/punishment was often used at the Kew Asylum from the many instances cited during the 1876 Inquiry.\(^{56}\) More 'modern' treatments however, were also capable of being appropriated as punishments. During the Inquiry, the members of the Board were entertained by Dr. Robertson's 'amusing anecdote' of how he forced croton oil, the most rigorous of purgatives down the throat of a patient who had abused him for his management of the institution.\(^{57}\)

**Rest, Diet and 'Medical Comforts'**

In conjunction with these often barbaric therapies, a much more gentle and acceptable form of treatment prescribed was that of rest and the addition of certain 'medical comforts' to the diet of patients. These included 'porter, [a type of dark beer] ale, brandy, sago, malt liquor, and beef-tea'.\(^{58}\) Unfortunately, the attendants who were totally responsible for dispensing these comforts were

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53 Foucault, *Madness and Civilization*, p.266.
54 Harrington Tuke, 'President's Address' *J MS*, vol.xix, no.87 (October 1873), p.330.
56 See Chapter Two, 'Life Inside the Walls' for further details of this 'treatment as punishment'.
57 Kew Inquiry 1876, p.67.
58 James, *Vagabond Papers*, p.87.
unsupervised and frequently unreliable. Those prescribed 'comforts' of the spirituous kind often did not reach the patient for whom it was intended. According to the findings of the Inquiry, many attendants 'had a drop too much and used to take the medical comforts themselves instead of giving it to the patients'. 59

There was usually however, a genuine attempt to ease the anguish of dying patients, for as Dr. Robertson explained a patient 'far gone' was given 'medical comforts usually brandy and water.' 60 Commonly, dietary additives were given as part of an overall treatment, in conjunction with drugs and sometimes also forms of humoral therapy.

Typical of this combination treatment was that administered to Agnes Jensen a 16 year old girl who was admitted on 18 May 1875 and diagnosed in spite of her youth, as a 'syphilitic dement'. During the seven months she spent at Kew, Agnes was subjected to a veritable bombardment of therapies. As the cause of her dementia was considered to be 'intestinal worries' she was prescribed a castor oil draught. She also endured a 'mustard and linseed poultice'. She was then moved to the 'tower,' an isolation block, as a suspected typhoid victim. The description of her symptoms merged together not only signs of both mental and physical ailments but included judgments about her behaviour. This meant that an ostensibly medical report noted that she had a 'stupid, vacant look', as well as a dry mouth and tongue, and a temperature of 102. Nevertheless, the deterioration in her physical condition was observed closely and Agnes's temperature and pulse were conscientiously recorded. By 23 May, it was noted that her temperature had risen to 103.6 and she could only 'with difficulty protrude her tongue'. She was placed on a diet of 'milk, beef tea, sago, and brandy'. On 25 May, she was given potassium chloride and nitric acid with water every three hours, and two days later a dose of castor oil which was said to have had 'the desired effect'. Spots confirming her typhoid appeared some days later, after which she appeared 'a little better'. To induce sleep, she was also prescribed chloral mist, but she was apparently improving steadily, physically at least. After a relapse, during which she had a

59 Kew Inquiry, 1876, p.89.
It was also specifically alleged that an officer named O'Conner had taken the keys of the store and helped himself to brandy, which he then diluted to avoid detection. (Source: Kew Inquiry, 1876, p.29.)

60 'Minutes', Kew Inquiry 1876, p.162.
fit, she was given extra brandy, chloral mist, nitric acid and another (illegible) drug. Her convalescence was slow but continual and apart from an attack of vomiting after meals, whereupon her usual diet was replaced by a 'prussic acid and milk diet' she recovered enough to be sent 'out on trial' during December. 61

The most consistently advocated cure for all types of insanity, however, was a notion that had come directly from Samuel Tuke and the Retreat. This was the concept of work, preferably work that required physical exertion:

Of all the modes by which patients may be induced to restrain themselves, regular employment is the most generally efficacious; and those kinds of employment are doubtless to be preferred both on a moral and physical account, which are accompanied by considerable bodily action. 62

So wrote Tuke in 1813. This view was clearly shared by Dr. Robertson who stated in 1876, 'I regard employment-occupation as the chief means of curing insanity of all kinds, and, with a view to that, I endeavour to see that as many curable patients are employed as possible.' 63 Although I have stressed in an earlier chapter that the work done by the patients contributed in no small way to the smooth running of the asylum, the doctors held a genuine belief that work was of real benefit to the patient. Upon being informed that, 'many of the patients did private work for the attendants Robertson replied that he, 'would rather they do this than nothing at all.' 64

Almost 30 years later, the Inspector of asylums still maintained in his annual report that 'employment is the most potent curative agent we possess'. 65 Employment was not only a means of cure but a key indicator of curability, as the patient's willingness to engage in work around the asylum was taken as a sign of improvement in their state of mind. Many casenotes recorded that a particular patient

61 PROV, VPRS 7397/P1, Unit 3, p.19.
62 Tuke, Description of the Retreat, p.156.
64 ibid.
‘seemed improved’, as they ‘now worked in the ward’, or simply ‘works a little’, or ‘does a little’, as if that in itself was confirmation of improvement. Sometimes, the case book was more specific about the type of work done, with approval being granted along gender guidelines. Elizabeth Patterson, Catherine Painter and Elizabeth Smeaton for instance were said to have improved, as they now worked ‘at sewing’, or ‘in the sewing room’, while John McCann and James Crofton were said to have exhibited signs of slight improvement when they ‘worked outside in the garden’. Alternatively, Martin Barry was both ‘unemployed and incurable’ and John Eyre’s original diagnosis of insanity was based partly on the fact that he ‘could not be induced to work at his trade of shoemaking’.66

Symptoms and Speculations

Unacceptable Behaviour

There were however, a number of other indicators that confirmed the initial diagnosis of insanity in a newly admitted patient. They were a combination of popularly accepted symptoms. These included hearing voices, undressing at inappropriate times and ‘unclean habits’, as well as public behaviour that tended to draw attention to an individual, such as loud and undirected conversation, or continuous swearing. Although any one or more of these factors may have been noted by family or friends when they took their relative to the asylum, once a patient was admitted the doctors often elicited information pertaining to other, more subtle changes in the patient’s demeanour. These changes may have appeared unremarkable at the time, but doctors often attributed them retroactively as being indicators of oncoming madness. As I have mentioned before, families or friends were reluctant to bring patients unless they became violent or otherwise uncontrollable at home. This apparent tardiness of families in bringing their relatives for treatment was interpreted by doctors as being part of a misconception held by them that insanity came upon an individual suddenly. Whether it was a

66 See PROV, VPRS 7397/P1, Units, p.113 for Bridget Cornely, PROV, VPRS 7397/P1 Unit 3,p.21 for Mary Humphries, PROV, VPRS 7397/P1, Unit 3,p.63 for Elizabeth Smeaton, PROV, VPRS 7397/P1, Unit 3, p.271 for Catherine Painter and PROV,VPRS 7398/P1, Unit 1, p.14 for John McCann, PROV, VPRS 7398/P1, Unit 1, p.47 for John Eyre, PROV, VPRS 7398/P1, Unit 1, p.53 for David Barry, and PROV, VPRS 7397/P1, Unit 4, p.285 for James Crofton.
deliberate misreading of the situation or not, the notion of a sudden attack of insanity was one which the medical profession was anxious to debunk. There were, they insisted, warning signs available to those capable of reading them. An article in the *Australian Medical Journal* in 1873 contended that:

> It was not long ago a very prevalent idea ... that insanity came upon its victims without giving the slightest warning; that a man went to bed well in the evening, and woke in the morning to find himself the prey of a terrible malady. To no popular delusion has the progress of scientific medicine dealt a more effectual blow.\(^67\)

These early symptoms included ‘protracted sleeplessness, persistent headache, loss of appetite, weight loss, and alteration in the state of nerves of special senses’.\(^68\) Despite the vagueness of these symptoms, and the fact that any one of them could have been attributed to a number of causes, doctors were anxious to stress that to ignore such early warnings was to risk the patient becoming irreparably insane. As the *Medical Journal* also observed, ‘a vast and frightful amount of chronic and incurable insanity exists at this moment ... which can be clearly traced to the neglect of the disease in the first or incipient stage’.\(^69\)

Most relatives continued to ignore the exhortations to bring patients to the asylum in response to such symptoms alone. Nevertheless, once in the asylum, patients were monitored for evidence of their existence. Sleeplessness was a particular problem. As Dr. Smith found, rather unsurprisingly, ‘I believe I am safe in saying that eight out of every ten patients under asylum treatment seldom enjoy a full night’s sleep’.\(^70\) Although this could indicate a confusion between cause and effect, it was duly noted that many patients had difficulty sleeping. Many other patients were not only restless, but ‘noisy at night’, which must have made it difficult for even the most sound sleepers to enjoy their usual rest. Some of these ‘difficult’ patients, however, were encouraged to rest by the sedatives given to them. On occasions, these simple procedures showed positive results. Mary Humphries was just

\(^68\) ibid., p.41.
\(^69\) ibid., p.43.
\(^70\) ibid., p.40.
one example. Mary was admitted in March 1875 in a profoundly depressed state. After five months of rest in the asylum, her depression had abated. According to her notes, she had recovered enough so that she ‘does not cry to [sic] much and was very anxious to go home’. 71

The appetite of inmates was also monitored and recorded, with an association drawn between a healthy appetite and an improvement in mental condition. Elizabeth Scott was committed in March 1876, after attempting to drown herself. Upon her arrival at the asylum, it had been noticed that ‘she does not look strong and says her knee is a little painful’. By 19 April, she was said to have been in much improved bodily health as ‘she has got quite fat, and does not speak about her delusions so much, and is less excited in conversation.’ 72 Elizabeth, who testified at the Inquiry in a ‘lucid manner’, was discharged in October of the same year. Soon after, her husband wrote a letter to Dr. Robertson thanking him for ‘the comfortable way in which she was sent home’.73 Although when she was discharged, the doctors concluded that Elizabeth was decidedly eccentric, it would appear that her eight months stay in the asylum with rest and wholesome food had effected a change for the better in both her physical and mental health.

Similar conclusions could be drawn for Benjamin Errey. Errey arrived at the asylum in ‘rather emaciated bodily health’. His notes also stated that, ‘he requires feeding and sleeps little’. After a few weeks he was reported to be ‘very greatly improved indeed’, sleeping well and talking quite rationally. He was moved to the convalescent ward and discharged 10 months later in April 1879.74 Errey however, possibly had more serious emotional or mental problems, as he was only admitted to Kew after he had become so violent that his wife had to ask for assistance in restraining him. 75 It remains unclear if he ever returned to Kew or any other asylum, or even how he or his family coped with him once he returned home. The connection between sound sleep, good appetite and mental state was, however, not always erroneous. It was people like Elizabeth Scott, Mary Humphries, and others

71Prov, VPRS 7397/P1, Unit 3, p.21.
72Ibid., p.60.
73Ibid., Letter from C. Scott to Dr. Robertson, October 1876.
74Prov, VPRS 7397/P1, Unit 6, p.270.
75Camperdown Chronicle, 29 April 1879.
in similar situations who most benefited from a stay in the asylum, away from the usual work and worries of their day to day lives.

**Inflaming the Passions**

Other traits that were also interpreted by the doctors as indicators of insanity were those that related to behaviour that appeared to be outside accepted societal norms. Some of these as previously mentioned were extreme, like loudly abusing strangers or undressing in public, while others were more restricted to personal moods or idiosyncrasies of patients. These so called symptoms were identified by excessive or inappropriate emotional responses to the patient's situation. They included 'great depression or exaltation of spirits without sufficient cause'. According to the *Medical Journal*, this could occur when either 'a man becomes depressed about his business affairs, and fancies himself on the verge of bankruptcy when all the while he is in good circumstances', or alternatively 'another may go to the opposite extreme. He is like a man in the first stage of intoxication-glorious ... he may be made to weep or laugh at the most trivial things.' Another symptom was:

> an alteration in the state of the nerves of special sense [whereby] a man fancies that his food has a peculiar taste ... that he hears voices speaking to him...that he sees spirits; or all this may be reversed; he may partially or totally become deaf, or lose the sense of touch. 76

Any of these symptoms seemed to indicate a failure on the part of the individual to have control of her or his sensual emotions. For Foucault, the 'savage danger of madness is related to the danger of the passions and to their fatal concatenation', 77 and as Martin Weiner has observed:

> The decades after 1820 saw a heightened concern with unregulated human power, both personal and collective. Virtually all the developments of the age were working to multiply the effective forces of human desires and will ... the question of control came to the fore ... extended to the

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76 Smith, 'Premonitory Symptoms' pp.41 and 42.

construction of personal identity [where] in personal life, it promoted concern with regulating one's passions and planning one's life.\(^7\)

Such blatant lack of control over 'one's passions' was therefore interpreted by members of the medical profession as an indicator of incipient degeneracy. As Dr. Smith, medical officer at Yarra Bend asylum, observed, 'Dr. Maudsley says lunacy is only one form of a protean neurosis, which circumstances develop into mental, physical, or moral disease. Thus, the causes of lunacy, crime and disease are one'.\(^7\) In addition, Smith contended, 'brain-symptoms may arise from over-indulgence of the passions, from long-continued habits of various kinds, or from fast living'.\(^8\) Within this discourse, degeneration, as a 'self-reproducing pathological process' is both symptomatic of the condition recognised as insanity, and the cause of it. Accordingly, one of the questions always asked of incoming patients was an inquiry into their 'habits of life'. The answer to this varied from 'regular or irregular, temperate or intemperate to drunken or immoral'.

In *The Classing Gaze*, Lynette Finch describes how, in late nineteenth century Australia, 'social surveys divided the lower orders into two groups. These were 'those who were moral and those who were not'.\(^9\) There is no doubt that once patients were confined in the asylum they were defined as probably 'immoral' or degenerate. They were then subject to continuous observation of their 'moral behaviour' in the expectation that they would 'prove' their degeneracy. This style of reasoning equated 'behaviour with type'.\(^9\) Thus, asylum staff were not surprised to find that Patrick O'Shea whose habits of life were defined as 'intemperate' was consequently 'dirty in habits', although he held 'no exalted delusions'.\(^9\) John Eyre, was not only unwilling to work at his trade but had 'the appearance of a masturbator'.\(^9\) Similarly, the notes on the severely depressed Mary Humphries


\(^7\) H.K. Rusden 'On the prevention of Lunacy', *AMJ*, vol.ii, new series, no.12, (December 1880) p.558.

\(^8\) Smith, 'Premonitory Symptoms', p.45.


\(^8\) ibid.

\(^8\) PROV, VPRS 7397/P1, Unit 2, p.256.

\(^8\) PROV, VPRS 7397/P1, Unit 1, p.47.
conjectured, without explanation, that it ‘seems probable that she commits self-abuse’. 85 Leon Lewis’s mania had begun it was also surmised, because of his frequent masturbation. He had, the Inquiry noted ‘become forgetful and talked oddly, a change of character that was attributed to the effects of an enervating habit 86, weakening a person of naturally excitable disposition and nervous temperament.’ 87 Likewise, the insanity of William James Catchpole seemed explained when he was ‘caught masturbating.’ 88

When the 45 year old Aboriginal woman identified only as ‘Betsy’ arrived at the asylum in December 1874, her habits of life were described as ‘drunken’. Consequently, the ‘supposed cause’ of her condition was declared to be ‘drink’. 89 The coroner’s report on the suicide of John Gibson declared: ‘I have no doubt his eccentricity would be greatly accelerated by indulgence of spirituous liquors’. 90 Interestingly, the ‘habits of life’ of Benjamin Errey were portrayed as ‘regular’, when as discussed previously he had become so violent that his wife felt compelled to apply to have him committed. Clearly, while conduct that deviated from accepted sexual norms, involved visible drunkenness, or offended utilitarian notions of behaviour earned descriptions of ‘irregular’, ‘intemperate’ or even ‘drunken’, violence against one’s family need not.

**Intemperance in Language**

Other aspects of patients’ behaviour that attracted comment were their use of ‘bad language’, and their willingness or otherwise to respond to questions put to them by the staff. Catherine Painter who was 40 when she was admitted in 1876, managed to offend many societal norms both inside and outside the asylum. According to the police report, she had been deserted by her husband. She was,

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85 PROV, VPRS 7397/P1, Unit 3, p.21.
86 The most common euphemisms used to describe masturbation were those that emphasised the ‘wastefulness’ of the act and therefore the profligate nature of the individual.
87 Kew Inquiry 1876, p.7.
88 PROV, VPRS 7397/P1, Unit 2, p.185.
89 ibid., p.267.
90 PROV, VPRS 24, Inquest Deposition Files, Unit 344, Item 558, (1876), Letter from Doctor who examined John Gibson after death.
however, living with another man by whom she had two children. Upon arrival at the asylum, she was 'not willing to speak or answer questions freely'. She was also reported shortly after her committal for fighting with another patient, and it was recorded that 'her language is very foul'. She was allowed out 'on trial' for a time but when she returned she was said to have been 'abusive and excited'. Although the cause of Catherine’s disorder was 'unknown' she was never to leave the asylum. She remained there for over 20 years until she died in 1897 from 'disease of the brain'.

Both John Eyre and Elizabeth Patterson were also difficult to interview. John was 'excited and abusive' while Elizabeth was 'silent, hardly answers a question'. It is highly likely that the refusal to cooperate with asylum staff in matters like this was a deliberate ploy by some patients— one of the few ways in which they could assert their independence. Elizabeth Patterson embarked on a long career in and out of asylums, eventually to die at Yarra Bend in 1894. Determined and uncooperative to the last, her final entry at Kew in February 1891 notes that she 'will not converse or put out her tongue'.

Assumptions and Comparisons

Neither Sense nor Feeling

Besides notions about recalcitrance, the ability of the insane to endure discomfort and pain as no sane person ever could had long been an accepted conviction within medical circles. Pinel was said to admire 'the constancy and the ease with which certain of the insane of both sexes bear the most rigorous and prolonged cold'. Dr. Neild, lecturer on forensic medicine at the University of

91 PROV, VPRS 7397/P1, Unit 3, p.271.
92 PROV, VPRS 7398/P1, Unit 1, p.47.
93 PROV, VPRS 7397/P1, Unit 3, p.254.
94 ibid., and Unit 9,p.228.
95 Foucault *Madness and Civilization*, p.74.
Melbourne and Government Pathologist, agreed. In an article in the *Australian Medical Journal* he wrote:

The insane show insensibility to thermal conditions. They will sit out of doors in the coldest weather, with hardly any covering on them and never shiver, and in the hottest days of summer they will sit bareheaded in the sun, seemingly quite indifferent to the heat.96

The Vagabond echoed similar sentiments when he found that the patients who were compelled to spend their days outdoors appeared quite impervious to the elements. In the yard that contained the most able patients he declared that:

Here, as in the side yard, there are some who, all day long stand exactly in the same place, insensible to heat and cold. 'Where there's no sense there's no feeling,' said an attendant to me; but still they suffer in their health from the inclemency of the weather, although they are unconscious of it. 97

Besides an insensitivity to heat and cold, the insane were also believed to be immune to physical pain which ‘in the sane, would have occasioned much suffering, but which [in the insane] had caused neither pain nor inconvenience’.98 Dr. Neild gave details of several quite bizarre cases where patients had supposedly demonstrated their indifference to pain. One of them was a rather gruesome anecdote involving a male patient identified as J.S. who was admitted to Kew as a melancholic. According to Neild, this particular patient, prior to his admission, had had ‘the blade of a pocket knife removed from the umbilicus’. The patient who was in ‘feeble bodily health’ claimed that he ‘had also inserted

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96 J. Neild M.D. “On the Immunity of the Insane from Physical Pain in Organic Disease, and in Injuries which in the Sane are accompanied by much Bodily Suffering”, *AMJ*, vol.x, no.2, (February 1888) p.57.

James Neild, besides being Government Pathologist was a lecturer in forensic medicine at the Medical School of Melbourne University for 25 years. He also served as President of the Medical Society of Victoria, and of the Victorian Branch of the BMA. He was also well known in Melbourne for many years as a theatre critic. See Presentation to Dr. Neild’, *AMJ*, vol.xii, no.9, (September 1890), p.423. He testified at the Zox Commission, in his capacity as Coroner, as at the time he performed all postmortems on asylum patients who died at the institution. See Brothers, *Early Victorian Psychiatry*, pp.100,137,143,176, and 178.

97 James,Vagabond Papers, p.103.

a darning needle through the same place as the blade knife, until it disappeared, and that he had 'swallowed some time previously a pound of paint'.

The article continued:

He was sent to bed, placed under special notice, but ... he never suffered in any way ... and after some time speedily regained his health ... .On the 20th of September, he stated to me personally, that he had swallowed a fork in the month of February [emphasis in original] last He was removed to the Hospital, and sent to bed ... at meal hours, he had been daily observed to run up the stairs ... On examination, there was a marked dulness(sic) limited by the cardiac area ... there was pain referable to the right shoulder, and evident distress in examining the abdomen ... some slight cough, but no vomiting. He sank very rapidly, and died on the 22nd.\textsuperscript{99}

This case served to vividly illustrate the belief of the medical profession that quite severe injuries or illnesses were thought not to impact on the mind of a person diagnosed as a lunatic. Although present, they were apparently without symptoms, or at least indiscernible to the patient. Dr. Neild also found that not only had he observed advanced cases of phthisis 'where there had been neither cough, expectoration, nor dyspnoea', but that 'fractures of the ribs seem to occasion no sort of inconvenience, and injuries of any kind are borne without complaint'.\textsuperscript{100}

According to the 1876 Inquiry, it was the severity of the insanity that determined whether or not a person was insensible to pain. The Board was concerned that not all insanity was 'so severe as to bring insensibility to pain' but concluded however, that 'lunatics feel little or no pain from broken ribs'.\textsuperscript{101} This was partly based on the revelation that Leon Lewis had two hitherto unsuspected broken ribs at the time of his death: a fact which was discovered during the post-mortem performed on him.

\textsuperscript{99} ibid., pp.55-56.

\textsuperscript{100} Neild, 'Immunity of the Insane', p.56. Note: C. MacDonald(ed), \textit{Butterworth's Medical Dictionary}, 2nd edition, London, 1978, p.555 defines dyspnoea as the 'subjective feeling of discomfort or distress which occurs when the need for increased pulmonary ventilation has reached the point of obtruding unpleasantly into consciousness'.

\textsuperscript{101} Kew Inquiry, \textit{VPP 1876}, vol.3, p.8.
He had been in noticeable pain, but the medical staff had attributed this to the fact that he had a broken ankle, as they (if not he) were unaware of the injury to his ribs.

A related, but somewhat contradictory assumption was probably the direct cause of Lewis's demise. This concerned a notion that held that the insane could tolerate a much higher concentration of drugs than a sane person, and furthermore the more severe the insanity the higher the rate of tolerance. As previously noted, Lewis was given almost a grain of morphine to help him sleep after the operation to his ankle. This was in addition to the chloroform he was administered during the surgery. He had also been prescribed copious drugs in the weeks before. Dr. Robertson was to admit at the Inquiry that 'It is undeniable that a grain of morphine is a very full initial dose, only bearable by the highest degree of acute mania'. The Coroner's report on Lewis found that 'appearances did not indicate death by narcotism', but also admitted that neither could 'morbid appearances met with after death ... alone prove mental disorder to have occurred during life'.

In spite of this however, postmortems were part of routine procedure on the death of any patient. The doctors were convinced that it was in this manner they would eventually discover the true nature of insanity. As Dr. Robertson proudly announced at the 1876 Inquiry, 'a coroner's inquiry is held as to the cause of every death that takes place at Kew', adding that they were made by 'three medical men unconnected to the asylum'. Victorian asylums were said to have been unique in the insistence that every death was to be investigated by post-mortem. There is little doubt that the postmortems often revealed, or at least confirmed the apparent immediate cause of the death of many patients. Nevertheless, in spite of the conscientiousness with which they were carried out, any revelation of an organic cause of insanity itself remained elusive.

102 ibid.,p.9.
103 ibid.,p.11.
104 Kew Inquiry, VPP 1876, vol.3, p.64.
Counting and Comparing

Despite a lack of genuine progress in either preventing or curing insanity, colonial doctors consoled themselves with the notion that there were fewer insane persons in proportion to the population in Victoria than there were in England. These comparisons with the nature and development of British institutions were an ongoing obsession within the Australian medical profession not only in an attempt to ‘keep up’ with British developments but seemingly to reassure themselves of the bona fide nature of their own work. A review article in the Australian Medical Journal in 1874 for instance, posed the explicit question, are ‘the insane more numerous in Victoria than in Great Britain, in proportion to the population?’  

We find that the number of insane gives a proportion of nearly three (2.94) to every thousand of the population in Victoria for 1873; while in England for the year 1872 (the statistics for 1873 are not yet to hand) the proportion of the insane to every thousand of the population was over two (2.54).  

they still remained convinced that there were proportionately fewer insane persons in Victoria. Their main justification for making this claim, against the logic of their own figures was the oft-repeated argument about Australian asylums being ‘burdened with a class of patients who have no business to be in them’. Doctors also suggested that surveillance in locating potential inmates was more rigorous in colonial Victoria than elsewhere. While many patients remained unregistered in England, living quietly with their relatives or friends ‘in this colony’, claimed the Inspector of Asylums, ‘it is certain that almost every person whose brain is affected in any degree is sent to an asylum.’

Other comparisons concerned the rate of increase of insanity, and the ratio of recoveries and deaths in Victorian and English asylums. By use of a somewhat tortuous logic, it was concluded that in

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106 ibid., p.212.
107 ibid.
Victoria, while 'the number of the insane in proportion to the population has been steadily increasing ... insanity is not increasing.' The rather dubious explanation given for this conclusion was that 'the actual number of the insane in a community is one thing, and the increase of the tendency to insanity in that community quite another'.\textsuperscript{108} Colonial doctors, however, seemed to have genuine reason to be sanguine about one aspect of their asylum treatment as compared to the English experience. There appeared to be many more patients who 'recovered' in Victorian asylums and certainly the death rate was far lower. 'The death rate in English asylums for the last ten years ... is 10.33 per cent., and in Victoria for the same period it is 8.37', the \textit{Australian Medical Journal} noted in 1874.\textsuperscript{109}

This desire to 'prove' that the insane were less numerous in a colonial context was not merely an affectation on behalf of colonial asylum doctors. It was also related to the theories held dear by Maudsley and others about civilization and improvement. While the insane population could remain relatively stable in Britain, (any actual increase caused concern) in the New World it was supposed to be possible to observe the degeneracy of the Old World being naturally worked out. Furthermore, emigration in itself was characterised as an aid in 'controlling one's passions', in that it helped to provide a suitable outlet for enthusiasm and adventurousness of spirit. As Harrington Tuke observed in London, during his presidential address to the British Medico-Psychological Association in 1873:

\begin{quote}
If emigration takes to other and kindred shores some of the finest of our peasantry, the best of our workmen, it also fortunately tempts the unstable, the enthusiastic, the adventurous, the disappointed, who, perhaps, remaining here, fretful and despairing, would have swollen the number of the insane'.\textsuperscript{110}
\end{quote}

\textsuperscript{109} ibid.
\textsuperscript{110} Harrington Tuke 'The President's Address for 1873' \textit{JMS}, vol.xix, no.87, (October 1873), p.335.
The Reassessments of the 1880s

Increasing Pessimism

Despite these reassurances, the optimism that had characterised the lunacy debate for the previous thirty years began to abate somewhat during the 1880s. Although any notions about the insane were still predicated on the view that they were a distinct, finite, and readily identifiable group of a 'degenerate type,' there was growing concern that they would not be so easily contained. This was allied to an increasing pessimism about the effects of civilization and about human nature itself. A contradictory hypothesis to the notion of continuous improvement as society sacrificed 'its earliest branches,' and all was 'for the best in the evolutionary survival of the fittest,' had been around for some time. This assumption, also couched within Darwinian evolutionary theory, was a contentious one within medico-psychiatric discourse, as can be seen by this excerpt from Harrington Tuke in 1873:

The hypothesis has been advanced, that the progress of civilization and the spread of education among the masses, have with a greater activity of brain produced a corresponding increase of nervous exhaustion and disease. This is a melancholy theory; it would unsettle our belief in the onward progress of mankind, it would shake the very foundation of our faith.111

Tuke concludes, however, that 'such a theory receives no support from statistics ...' and hastens to explain that in his view, 'the explanation is to be found in higher wages, and the consequent means of undue indulgence'.112

Although Tuke's initial view was essentially optimistic, the creeping doubt he expressed about the ability of some members of the 'lower orders' to cope with advancing civilization gradually assumed

111 Harrington Tuke, 'President's Address', p.335.
112 ibid.
more dramatic proportions. Tuke, in common with other social commentators, experienced a marked decline in the belief of the essential rationality of all humans. As the eminent Darwinian zoologist Edwin Ray Lancaster was to remind his peers in 1880, evolution was a two edged sword. 'It is well to remember', he warned, 'we are subject to the general laws of evolution, and are as likely to degenerate as to progress'.\textsuperscript{113} This type of thinking came to dominate social commentary, and policy making as:

> evolutionary scientists, criminal anthropologists and medical psychiatrists confronted themselves with the apparent paradox that civilization, science, and economic progress might be the catalyst of, as much as the defence against, physical and social pathology. \textsuperscript{114}

It was in 1883 that Francis Galton introduced the term 'eugenics', and although it was some time before his ideas received widespread articulation, the notion that humankind would not universally automatically improve without direct scientific intervention had been conceived. As Martin Weiner explains it, 'running through late Victorian policy-making can be traced a mental thread of diminishing faith in the rationality, freedom and efficacy of the will power of the individual.\textsuperscript{115}

Most notably, within the medical profession, Henry Maudsley abandoned his earlier optimism in the ability of most humans to adapt and improve, or alternatively, rapidly breed out. 'Alongside a process of evolution,' he explained, 'there has always been in operation a process of degeneracy, and the simple question is whether this process will not eventually gain the upper hand'. \textsuperscript{116} Gradually, he became convinced that the degenerate threatened to overwhelm rational society. This he attributed at least partly to ill-conceived social policies. Maudsley, as interpreted by the Australian Medical Journal in 1880, expressed the concern that an apparent increase in the number of lunatics was a direct result of 'protecting' those who carried the 'protean neurosis' or degenerate gene.\textsuperscript{117} According

\textsuperscript{113} Quoted in Pick, Faces, p.217.
\textsuperscript{114} Pick, Faces, p.11.
\textsuperscript{115} Weiner, Reconstructing the Criminal, p.126.
\textsuperscript{117} Rusden 'Prevention of Lunacy',p.558.
to the article, ‘150 years ago lunatics were exterminated by ill usage, now lunatics and criminals are petted and preserved’.\textsuperscript{118} In addition, Maudsley’s influential \textit{Body and Will} (published in 1883) reflected throughout, according to the review in the \textit{Journal of Mental Science}, ‘a startling pessimism’. It ended with a ‘final dirge’ inquiring, “What will be the end thereof?”\textsuperscript{119}

\textbf{Victoria’s Growing ‘Lunacy Problem’}

This degeneration discourse with its pessimistic emphasis, coalesced with the increasing disquiet within the colonial medical profession about the situation of insanity in the colonies, Victoria in particular. In contrast to early optimism that the number of insane would be ‘worked out’ within a generation or two, it appeared that the numbers were continually increasing. A preoccupation of the age, no less in the Australian colonies than in Britain, was an obsession with statistical data. The constantly rising numbers of asylum admissions recorded in annual reports made it appear that Victoria was experiencing an unprecedented rise in insane persons during the 1880s. The observation that asylums, (especially Kew), were becoming more and more overcrowded seemed to confirm this ‘increase in insanity’. Concern over this grew, as commentators suggested that the proportion of insane in Victoria continually outstripped the numbers in neighbouring colonies as well as in Britain.

Dr. Frederick Norton Manning, Inspector General for the Insane in NSW, calculated in the \textit{Australasian Medical Gazette} that by 1880 ‘the number of insane in Victoria was 3,065, or 3.58 per 1,000 of the population ‘ as compared to 1861 when it had been 1.29 per 1,000’.\textsuperscript{120} This represented the largest increase of all the colonies. Likewise, the Zox Commission in 1886 recorded that, ‘Victoria held the unenviable position of having a larger percentage of insane than any of the neighbouring colonies’.\textsuperscript{121} The absurdity of some of these predictions however, was revealed when the \textit{Australian Medical Journal} came to the startling conclusion that if the numbers of insane

\textsuperscript{118} ibid.
continued to increase at their current rate in Victoria, ‘all the children of the fifth generation would be insane, with no sane people to provide for them at all’.  

The 1883 Annual Report on asylums in Victoria admitted that ‘our standard of measuring madness is excessively severe’, implicitly acknowledging that the doctors had a role in deciding who was mad. Despite this, there seemed to be little understanding among asylum doctors that they were also involved in the construction of a view of an inmate population that categorised them as essentially deviant, immoral or degenerate. According to Foucault, the asylum ‘no longer punished the madman’s guilt ... it organised that guilt ... In other words, by this guilt the madman became an object of punishment.’  

Maudsley’s remark about the ‘petting and preserving’ of lunatics reflected a similar philosophy. Also corresponding with this thinking was the notion that while Victoria was ‘heading the list [in numbers of insane] with one insane person in every 294’, what was required was a thorough revision of lunacy treatment headed by medical men of strength and purpose who would exert more control.

**Changing the Doctors**

In this regard it seemed Victoria’s asylum doctors were generally lacking. When Paley resigned in 1883, after having been Inspector of Asylums for over ten years, his peers were quick to criticise both him and his incoming replacement Dr. Dick for their lack of ‘strength’. Of Paley, the *Australian Medical Gazette* remarked:

> Perhaps a plainerter, more amiable man never existed, but just because he has been so pleasant and so amiable he has failed to grapple with the difficulties of his position ... the whole scheme

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of treatment of the insane in this colony needs revision ... only a strong and wise man can
successfully deal with the revision.126

Similarly, it was felt that Dr. Dick, who had been Superintendent at Kew since 1877, although 'a
good practitioner, an estimable gentleman ... wants the the energy and force of character necessary to
reorganise the entire system of lunacy treatment in this colony'. The editorial went on to suggest that
'the man who ought to be appointed to this office is Dr. Fishbourne'.127 Although regarded as a
visionary by many of his peers, Dr. Fishbourne128 was also intensely conservative and somewhat
patriarchal. He had left the lunacy department in 1881 in frustration that his suggested reforms were
not implemented. Fishbourne testified extensively at the Zox Commission, advocating 'more control
by the Superintendents over their staff'. He also suggested that a certain 'class [of patients] require a
course of treatment that will straighten them up'.129

Because the understanding of degeneration held by colonial doctors was essentially Lamarckian, any
inherited tendency remained susceptible to alteration, and therefore to intervention. Thus
heriditarianism did not exclude environmentalism. Dr. Cleland, medical officer from Parkside
Lunatic Asylum read his paper 'Insanity During Pregnancy', to the South Australian branch of the
BMA in 1886. In it he asserted:

It [insanity] is essentially a product of family development ... families may grow into or out of the
insane diathesis, but no-one develops these diathetic conditions full blown in his own person ... it
is essentially of an evolutionary nature ... With the help of the asylum surroundings, three out of
four are as a rule[made to be] fairly rational and able to employ themselves ... if the home

127 ibid.
128 John York William Fishbourne was a general practitioner before he came to Victoria from Ireland. He spent
10 years in the area of mental disease, in Victorian public asylums firstly as a medical officer at
Beechworth, then at Kew, leaving the department in 1881. At the time of the Zox Commission he was in
private practice. He was an advocate of training asylum doctors specifically in the area of mental health
adding that he would like to 'see a man of European reputation as clinical lecturer in charge of the
teaching asylum'. He founded the first day school for mentally defective children in the mid 1890's. The
school ceased to function two years after his death in 1913. (Source: Early Victorian Psychiatry, p.12.)

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surroundings are not compatible ... advantage should be taken of the accommodation provided by the State.\textsuperscript{130}

That the accommodation provided by the State often fell short of what was desirable did not go unnoticed. Medical staff, especially superintendents, continually complained about the facilities at their respective institutions. Although the numbers at Kew grew to overcrowding levels during Robertson's superintendency, it was during Dr. Dick's time (1877-1883) that the building and its facilities fell into disrepair. Dick complained about the state of the building and the lack of amenities to no avail. It was McCreery\textsuperscript{131} who took over in 1883 who most forcefully put ideas about environment into practice, and compelled the administrators to make some improvements. In 1886, at McCreery's insistence:

23 single rooms were added, the water tanks were repaired, new mains were installed so that water was laid on in the laundry, additional closets were built, and many small repairs and alterations were carried out ... The labour yards and another large extent of ground was planted with shrubs and trees'.\textsuperscript{132}

It was during also the McCreery years that the principles of moral restraint began to be put into effect in earnest. Humoral therapies were largely abandoned by the middle of the decade, seclusion and mechanical restraint were minimised, and the rhetoric emphasised self-help within a congenial, but controlled environment. Medication continued to be used to sedate and calm, but overall, because of the increasing numbers, 'treatment' became largely custodial.

\textsuperscript{130} W.L.Cleland, 'Insanity During Pregnancy', \textit{AMG}, vol. vi, no. 7, (July 1887), p.242-3.

\textsuperscript{131} Dr. James Vernon McCreery (1894-1905) was born in Kilkenny Ireland of Scottish parentage. He graduated in 1864 from Trinity College, Dublin with the degree of L.R.C.S.I. He joined the Victorian Lunacy Department in 1868 as assistant medical officer to the Superintendent at Ararat. He then transferred to Kew, and in 1877 was promoted to the rank of Superintendent at Ararat. In 1883 he succeeded Dick as Superintendent at Kew. [Source: Brothers \textit{Early Victorian Psychiatry}, p.167]

\textsuperscript{132} Annual Report 1886, \textit{VPP1887}, vol.2, pp.19 and 44.
Education and Surveillance

McCreery was a complex man; a tireless worker dedicated to the notion that adjusting the environment of patients could make a difference to their condition. He was also a believer in making the insane accept responsibility for their own actions. He saw the means of cure to lie within the insane themselves. He believed they could be ‘taught’ to improve through formal education or ‘shamed’ into improvement by increased surveillance. It was during his time that the first three detached cottages, two for boys and one for girls, were erected and 52 children were removed there. Both Dick and McCrerey had asked for separate accommodation for the younger inmates because they claimed they were ‘not safe with the men in the main institution’. The Board of the Zox Commission recommended that ‘an asylum be built for idiot children, provided with proper persons to teach them ... useful knowledge [and] that no children be confined in wards with adult lunatics’. Some educational instruction was organised for these young people. According to the 1889 Annual Report, McCrerey and an officer from the Royal Albert Asylum in Lancaster, England:

zealously strove to instil into the children such rudimentary knowledge as their condition will allow. Efforts to teach them meanings of words, and figures by object lessons ... and they are taught habits of regularity and cleanliness. As soon as circumstances will allow it is proposed to give industrial training to more promising children.

According to C.R.D. Brothers, the ‘imbecile children were fortunate in being placed in the charge of McCrerey, who, by his keen interest, was largely responsible for the success of the institution’. As proof of this success, Brothers offers the following information:

In 1889, the Psychological Section of the Medical Congress, held in Melbourne that year, visited these ‘Cottages for Idiots’. The President spoke of the institution as a distinct advance on

133 ibid., p.43.
anything yet done in Australia for feeble minded children. By this time the boys were capable of gardening, and making simple articles of furniture, and the girls able to assist in the laundry and kitchen.\textsuperscript{136}

It is difficult to assess how great a benefit this training was to the children themselves, or whether it merely made them more vulnerable to exploitation. In 1891, the Inspector of Asylums, Dr. Dick, claimed that:

the children appear to enter these occupations [making furniture, cultivating land, assisting in the laundry and kitchen] with much greater zest than they display in the school room, where there is probably larger, and possibly excessive demand on their mental capacity'.\textsuperscript{137}

By 1892, he had reason to be pleased that more girls had entered the cottages as they ‘find useful occupations in the laundry where they do the washing for the cottages’.\textsuperscript{138}

McCreery also requested schooling for adult inmates as a therapeutic treatment. After several requests, '[McCreery] was allowed the services of a teacher for male adults, with the object of bringing the more inactive under some form of training after the manner of a few of the Irish asylums'.\textsuperscript{139} This experiment was deemed a failure however, and abandoned after the first year. The Inspector General gave the following reasons:

The results were not so encouraging as to warrant the continuance of the extra expenditure involved ... At the end of the year the teacher was sent away without any arrangement being made to supply his place, the result being the ninety patients were sent back to their airing courts and the ‘interesting experiment’[ emphasis in original] came to an end.\textsuperscript{140}

\begin{footnotes}
\item[140] ibid., p.48.
\end{footnotes}
McCreery could hardly be held to blame for the department’s lack of willingness to spend extra money on his patients in this regard. In apparent contrast to his desire to educate inmates and make them more self-reliant, however, McCreery was also an advocate of increased surveillance to instil acceptable habits. He reported his success with a group of ‘wet and dirty female patients’:

Early in the year I placed a special female nurse in charge of three dormitories containing about seventy beds that open onto one passage. Into these dormitories I collected almost all the wet and dirty female patients and was much pleased to find that in the course of a few weeks of constant night care and watching they were all broken of their bad habits; one was subsequently discharged recovered, and several others have become most useful members of the asylum workers. 141

McCreery consistently maintained that patients could be ‘improved’, demonstrating a belief in their essential humanity. This notion of improvement, however, was always couched within the understandings of middle class respectability. Often, in very subtle ways, this was reflected in the reports on patients. For instance, Emma Scarlett, it was recorded approvingly, had not only been ‘quiet and rational for the past two months’, but she had also been ‘attending church’. 142 Margaret Middleton who on arrival was considered to have ‘the appearance of a woman who drank’, was described after a few months as ‘quieter’ and subsequently discharged. 143

In a variety of ways, both important and trivial, McCreery tried to improve the environment for patients. Theses enhancements ranged from better food to extra billiard tables. They also included the acquisition of a donated piano, as well as ‘many little decorations giving a comfortable home-like appearance’. 144 Paradoxically, however, he warned against providing accommodation that was too comfortable as ‘comfortable homes ... with little supervision, may tend to increase the number of

141 Annual Report 1887, VPP 1888, vol.3, p.44.
142 PROV, VPRS 7397/P1, Unit 8, p.231.
143 PROV, VPRS 7397/P1, Unit 8,p.259.
people on the borderland of insanity who are only too willing to hang about any public institution’. 145 In common with his predecessors, McCreery had definite notions about who should be excluded from the asylum. Such a patient was Robert Edwards, a 70 year old shoemaker who was admitted in April 1884. Medical staff agreed Edwards was ‘not a fit case’ for asylum treatment. Sympathetically, the attending medical officer classified him as ‘a poor broken down helpless man, having been a patient in Daylesford hospital for the past five years’. He added ‘I do not consider him a suitable case for asylum detention’. Edwards died just a month after his admission, in May 1884. He was granted the ‘usual comforts’ having his ‘brandy increased latterly’ as he lay dying. 146

**Restraints and Injuries**

With the gradual abandonment of mechanical restraint, there appeared to be a corresponding increase in more direct physical control by staff members. This is suggested in the language of a number of cases. It is portrayed graphically in the notes pertaining to Margaret Middleton. When Margaret came to the asylum in 1888 she was described as ‘very hard to manage’. She also had a habit of ‘talking impertinently to the matron and medical officers’. After a few weeks, she was again noted to be ‘very difficult to manage’, At times she became ‘very violent’ and ‘it took several attendants to restrain her’. On another occasion it took ‘three attendants to mind her’.147

During the 1880s, there was also an increase in the number of injuries to patients. This was possibly unavoidable to a certain extent with such a volatile population in such large numbers. Nevertheless, it was a disturbing trend and many of the injuries were serious. In 1881, for example, there were seven recorded ‘casualties’. Among them were four cases of fracture, including a patient identified as H.G who fell from a window and broke his collar bone. There was also one successful suicide. The patient J.B. evaded the attendant and ‘hanged himself from a tree in the secluded part of the grounds’. 148

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145 Annual Report 1887, VPP 1888, vol.3, p.44.
146 PROV,VPRS 7398/P1, Unit 9, p.4.
147 PROV,VPRS 7397/P1, Unit 8, p.259.
During McCreery’s first year in 1883, there were only two serious accidents, both resulting in fractures. In 1884, there was only one critical injury recorded. During 1886, however, there were three instances of broken bones, and in 1887 there were seven recorded casualties including two deaths. In the first a patient, P.H. fell from a cart and fractured his skull. This may have been simply an unhappy accident, but the second fatality indicated at least a lack of supervision, if not negligence. In this instance a patient, J.S., died from internal injuries after swallowing a fork. Other injuries included two broken legs, one of which occurred when the patient tried to climb the fence. Officially, no blame was attached to any attendant.149

In 1889, a total of nine patients were seriously hurt, including a male who hanged himself, and a female who died while being fed. Other casualties included two broken legs, two broken arms, and an 87 year old female patient who injured her hip.150 Many of these injuries could have occurred anyway, as these people may have been more prone to accident than the general population. Nevertheless, the frequency of injury indicated a lack of experienced staff who could have minimised such problems. Added to this was the ever present possibility of epidemics of disease, such as the outbreaks of typhoid. It would seem that there was little danger of the asylum becoming too appealing for those on the ‘borderland of insanity’ as McCreery feared.

Training Nurses

McCreery’s major legacy in a therapeutic sense was undoubtedly the role he played in securing training for nurses. When the asylum first opened the warders or attendants were untrained and ‘part nurse, part servant, part artisan, and generally of a low calibre’.151 There was no distinction created between types of employment, and staff members could nurse patients one day, work in the wards as

151 Brothers, Early Victorian Psychiatry, p.172.
cleaners the next, or help out in the gardens. It was McCreery who suggested that the staff should be
divided and that nursing the patients should be a specific and full-time occupation. As he explained it:

The plan of calling warders, all the nurses, servants and artisans is objectionable ... if a first class
nursing staff is to be formed, the nurses must be kept separate from the other two classes, and
trained for their special work, as in a general hospital. \(^{152}\)

In 1887, Dr. O’Brien, the deputy medical superintendent, gave the first lectures to interested male
warders at Kew. Commenting on this, McCreery said, ‘This I hope is only the beginning of a
strenuous effort to develop the nursing powers of warders’. \(^{153}\) He was supported by the Inspector of
Asylums Dr. Dick, who hoped to make such training compulsory. The training of nurses for the
insane was more advanced in NSW, and Dr. Manning confidently predicted in 1889 that:

Within another decade no attendants or nurses will be employed in State Hospitals for the Insane
in these colonies ... who have not gone through a systematic course of training and instruction in
their duties, and received certificates of their fitness for their special work. \(^{154}\)

Accordingly, when McCreery became Inspector of Victorian Asylums in 1894, his plan for training
nurses based on the NSW system was approved by the Chief Secretary. Subsequently, he noted that
lectures were given in all asylums to both male and female attendants. \(^{155}\)

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\(^{152}\) ibid.


\(^{154}\) Manning, ‘Lunacy in the Colonies’, p.92.

Re-evaluating the Therapies

Refining the Cures

Although the training of nurses was no doubt of immense benefit to asylum patients, any notion that it heralded a general professionalisation of treatment relating to insanity was largely unfounded. Doctors were floundering in the void left by the rapidly disappearing humoral therapies, all too aware that the scientific breakthroughs they had anticipated were not forthcoming. They were also overworked and overburdened with larger than ever inmate populations.

In an effort to compensate for a lack of effective treatment, and given the passion of the time for statistics and classification, a major concern became the re-assessment and re-evaluation of the various forms of insanity. The *Australian Medical Journal* in 1874 had identified four major 'forms of insanity ... mania, melancholia, monomania, and dementia',\(^{156}\) following the *Journal of Mental Science* in 1873 which had also added 'imbecility and idiocy'. However, Dr. Skae was concerned that this method of classification had become outmoded, as they 'were not a classification of diseases or forms of insanity, but a classification of symptoms'.\(^{157}\) Skae then proceeded to nominate no less than 34 different types of insanity, distinguished from one another through their supposed causes. Included in this list was a number of afflictions like 'peurperal insanity, ovarian insanity, delirium tremens, anaemic insanity, insanity of masturbation and insanity of alcoholism'.\(^{158}\) Australian doctors were also anxious to identify, and consequently treat, different forms of insanity according to their 'common bodily pathological cause'.\(^{159}\) The *Australasian Medical Gazette* noted in 1883 that peurperal insanity would respond to a specific curative treatment, asserting that in 'no case of insanity is a good dose of chloral more useful'. The same article also noted that to 'persuade a [potentially suicidal] patient just to drink a little milk or wine on first admission' would be most beneficial. In

\(^{156}\) Dr. P. Smith 'Hints on Giving Lunacy Certificates', *AMJ*, vol.xix, (January 1874), pp.18-19.
\(^{158}\) ibid., p.348.
\(^{159}\) ibid.
addition, the ‘wet pack as a temporary means of restraint, or as a sedative in cases of sudden and transitory delirium, is exceedingly useful’. A later article on insanity during pregnancy, concluded that ‘for the excited and destructive class, the bromides, with occasional stronger alternative medicines, generally answer well.’ Clearly, none of these treatments were new, it was simply that they were to be applied more selectively.

Diet maintained an important role during the 1880s, with particular foods sometimes implicated in specific types of insanity. In this respect, the comparatively large amounts of meat consumed in the colony came under suspicion. The English-born Dr. Fishbourne, who held the position of medical officer at Beechworth Asylum for two years, testified at the Zox Commission that ‘over-indulgence in animal food causing fibrine in the blood is frequently the origin of mental disease.’ Dr. Campbell Clark, a Scottish alienist writing in the Journal of Mental Science claimed that he had developed a dietary regime, eliminating meat, that had discouraged three male masturbators from their habit. He explained it in detail:

For four and a half months, I experimented with diets of either 1. meat; 2. fish 3. Irish stew or 4. rice, milk and fruit tart ... after the first three diets these patients frequently masturbated, but in no case after rice, milk, and fruit tart.

Although Australian doctors made no such definitive (or eccentric) claims for specific cases they consistently recorded the appetite of patients, often modified the diet of certain inmates, and force-fed those who refused to eat. As the Gazette maintained in 1889, ‘the importance of a generous dietary, indeed of a wise liberality in the matter of food is fully recognised, and not a few of us are disciples of the “gospel of fatness”’. According to the reports of both the Vagabond in 1876 and Dr. Paul Farmer in 1900, food at Kew was not necessarily of good quality, but it was plentiful. The


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establishment of a vegetable garden and fruit trees at the asylum eventually improved the quality of food. However, pilfering of the better specimens by staff members was far from uncommon.

The Scientific Mission

During the 1880s, one new and innovative treatment was contemplated: electricity. The Journal of Mental Science in 1883 reviewed a book that detailed the, 'uses of electricity as a physical agent in the diseases of the nervous system'.\textsuperscript{165} This was followed in 1888 by an article in the Australasian Medical Gazette which specifically described the uses of electrical treatment:

\begin{quote}
The influence of electricity on some of the more obscure nutritious changes is recognised, and the treatment of some forms of insanity by the continuous current has been more than favourably reported.\textsuperscript{166}
\end{quote}

Ultimately however, the writer of the article remained unconvinced, asking, 'has galvanism been with us thus, except in a few instances, much more than a scientific toy?'\textsuperscript{167} There is some evidence to suggest that electrical treatment was used at the Kew Asylum, but not until much later and never very extensively. In 1888, doctors opted instead for more traditional remedies, urging 'a more liberal, and more accurate and ... a more continuous employment of drugs'. The same article also queried, somewhat rhetorically, 'Do we employ the alternatives such as arsenic and the milder mercurials, the alkaline salts, and the nerve and vasi-motor tonics and stimulants with sufficient discrimination and for sufficient periods of time?' Alternatively, with what might be described as the last vestiges of humoral therapy being reconstituted as scientific medicine it asked, 'Is the Turkish bath employed either as frequently or as fully as it might and should be, and is our use of simple or medicated baths carried out even to the full scope of the means at our command?'\textsuperscript{168} Regardless of the rhetoric which

\textsuperscript{166} F.N. Manning, "On Lunacy", p.91.
\textsuperscript{167} ibid.
\textsuperscript{168} Manning, 'On Lunacy', p.91.
promoted innovation, in practice, treatment became primarily custodial. This was despite constant claims that: ‘asylums are places for treatment ... [and] should not be refuges for the poor people under consideration’. 169 Ironically, the greatest contribution of the asylum was probably when it was used in this very manner: when it acted simply as a refuge for people either temporarily or permanently suffering from some degree of inability to cope in the wider society.

While tonics, plenty of food, ‘pure air and bright sunshine’, 170 besides the ubiquitous ‘work’ remained the prescriptions for the cure of insanity, results were consistent, if unspectacular. In addition, the many patients who arrived with physical ailments were often helped, or even completely cured by the treatment they received. Unfortunately, the overcrowding, the lack of basic amenities and the poor standards of hygiene, often worked to negate any benefit patients may have enjoyed, whatever the state of their mental health. The medical staff were generally well-meaning and basically compassionate men caught between conflicting agendas. On the one hand they were genuinely concerned for the patients under their care. At the same time, they were ambitious, wishing to prove through their results that they had discovered a cure for insanity through their ‘enlightened scientific methods’. They were also continually frustrated by lack of funding, and what they saw as a general misunderstanding of what they were trying to achieve. The custodial role which families, the community, and sometimes the patients themselves wished them to fulfil was one which they were anxious to relinquish, claiming for themselves a grander mission.

Despite the fact that the ‘latent insanity’ in the Australian population did not appear to be ‘naturally working out’, there remained an increasing conviction among doctors that the Australian colonies could still lead the way in developing scientific answers to lunacy. As the Zox Commission concluded, ‘Hospitals for the new and acute cases should be furnished with every scientific apparatus. ... careful records should be kept ... each medical man should keep himself well acquainted with the literature of the day’. 171 It was anticipated that with additional expenditure and increased European

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170 O'Brien, 'Points of Interest', p.213.
expertise, Australian asylums could become laboratories in which to develop the cures for madness. In 1889, the *Australasian Medical Gazette* predicted, 'among other things, our hospitals should be great fields for brain surgery, the brilliant results attending which are of the highest interest and importance'.

With the change in the rhetoric, asylums were always referred as 'hospitals' and the emphasis was on the 'the pathological, the microscopical, and the scientific'. However, one facet of asylum life remained constant. Reluctant to admit their enduring bafflement at the most perplexing of human ailments, the doctors continued to claim an expertise and an understanding of madness that was not reflected in either treatment or results.

173 ibid.
CHAPTER 5

The Birth of The Hospital

In the clinic one is dealing with diseases that happen to be afflicting this or that patient; what is present is the disease itself, in the body that is appropriate to it, which is not that of the patient, but that of its truth. A way of teaching and saying becomes a way of learning and seeing.

Michel Foucault.¹

The Metropolitan Hospital for the Insane should be in a manner affiliated to the University, and should be a school of practical teaching. The most desirable and necessary onward step is a more extended, larger, and more accurate scientific study of insanity.

F.N. Manning 1889.²

The notion that the asylum was no longer simply a place of refuge, or even primarily a place of cure, but a place for the discovery of the ‘truth’ about lunacy signalled yet another important shift in the discourse of insanity. It not only involved a style of reasoning that equated behaviour with type (as discussed in the previous chapter), but superimposed upon this belief a view about the possibility of recognising, and then divorcing, the degenerate from the rational population. This presupposed an essentially organic perception of society, reinforced by a related hypothesis which maintained that it was then also possible to observe and abstract the ‘essence’ of madness from the person in whom it occurred. Conversely, in Foucault’s words, ‘In order to know the truth of the


pathological fact, the doctor must abstract the patient.'3 The successful outcome of this process meant that madness would become, 'a thing to look at'. 4 The purpose of this chapter then, is to ‘look at madness’, through the interpretative tools employed by the medical profession—and largely reinforced by societal attitudes—during the closing days of the nineteenth century, and in which twentieth century psychiatry had its foundations.

The case books of patients contain a classification system based on the observations of police, or admitting doctors, families and friends of inmates and the medical staff of the asylum. Through these case books and the medical journals, I explore the construction of the patient population around the years of Federation, continuing until the early months of 1915. The Australian experience, explored here largely through the records from Kew, shared many common assumptions with its counterparts in the UK or elsewhere. However, at times it was either modified or exaggerated by additional features peculiar to colonial societies, and, more particularly, to a nation in the process of ‘inventing itself’.

The idea of being able to observe a disease or illness itself was not exclusive to notions about madness, but came from the emerging theories of a wider, mainstream, medico-scientific discourse. These were described as a change from ‘a person oriented toward an object oriented cosmology’.5 The same idea also provided the theoretical legitimation for attempting what Donzelot has described as the ‘psychiatrist’s yearning to leave the asylum in order to become the agent of a project of social regeneration’. 6 This notion had been formulated from the mid nineteenth century, as explained by George Robinson, a lecturer on medicine and mental diseases at the University of Durham. In a paper given in 1859, he had urged that in order to study and check the progress of insanity the physician needed to ‘look beyond the precincts of the asylum’, and that ‘the most useful field of

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3 Foucault, Birth of the Clinic, p.8.
4 Foucault, Madness and Civilization, p.70.
6 Donzelot, Policing, p.128.
study is that constituted by the circumstances and associations, the physical and moral conditions surrounding the masses from which their victims are taken.\textsuperscript{17}

This perception struck a particularly strong chord within the Australian medical profession, largely because of notions about the ‘knowability’ of the Australian population as discussed in the previous chapter. It was explicitly expressed in 1906 in an article in the \textit{Intercolonial Medical Journal of Australasia} which announced:

\begin{quote}
The whole of this “defective class” [which was noted elsewhere in the article as the sick and feeble, inmates of lunatic asylums, criminals, and children who were mentally or physically defective] have a right to be protected against themselves, and the control which they lack should be supplied to them from without; at the same time society has a right to be protected from the transmission of their defective qualities to future generations.\textsuperscript{8}
\end{quote}

Since the problem had become not a person but an object, or more truly a set of ‘defective qualities’, attached to certain people, then it could be found and extracted from the general population. Thus, doctors not only confirmed their role as ‘curers of insanity’, but their responsibilities expanded so that it was also their function to ‘rescue’ the community from its dire effects and prevent the propagation of it into the next generation. Within this understanding, the ‘self-reproducing’ abilities of degeneration became the major concern, as it threatened to overwhelm rational society if its early carriers were not weeded out, and separated from the rest of the community. In this chapter, I propose to trace and explore the discursive constructs of the last decade of the nineteenth century, and the early twentieth century, within which asylum doctors laid claim to a mission as social regenerators and in the process reconstructed asylums as ‘hospitals for the insane’.

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The Appearance of Insanity

The Underlying Theories

Confident in their ability to distinguish the degenerate from the rational, doctors applied two main guidelines in confirming those brought to them as suitable inmates: these were appearance and behaviour. Appearance had always been an important tool in the definition of insanity. According to popular opinion, the insane had a ‘wild-eyed’ or ‘deranged’ look’. More specifically, during the nineteenth century certain distinctive characteristics or changes in bodily or facial appearance were attributed to the onset of madness or mental deterioration. The French psychiatrist Bernard Augustin Morel in 1850 claimed to have determined changes in the head, eye, ear, genitalia and intestines which he described as infallible stigmata of degeneration.9

The recognition of the degenerate through certain facial characteristics came out of the diagnostic procedure known as Physiognomy. This doctrine of Victorian medicine was defined in a medical dictionary in 1855 as a ‘study of the general character, or of diseased states’.10 A number of disorders, including those of the digestive or bronchial tract, as well as the nervous system were identified through a study of the patient’s appearance.11 The concept of Physiognomy, along with the related practice of Phrenology, had been a traditional part of medico-psychiatric methodology for a number of years before asylums in Australia employed them systematically.12 Physiognomy however, was rendered

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9 Ackerknecht, A Short History, p.49.
11 ibid.
12 According to Stedman’s Medical Dictionary, Phrenology was ‘the theory that the various faculties of the mind occupy distinct and separate areas in the brain-cortex, and that the predominance of certain faculties can be predicted from modifications of the parts of the skull overlying these areas where these faculties are located’. (Source: I. L.Stedman, Illustrated Stedman’s Medical Dictionary, 24th edition(1st edition 1911), William and Wilkins, Baltimore, 1990, p.1083) Hoblyn describes it as ‘the science of the mind, characters and propensities determined by conformation and protuberances of the skull. (Source: Hoblyn,
more efficacious with the widespread use of photography. The employment of technology served to further legitimise the procedure. When photographs could be taken and studied at length from various angles by doctors, the process of observing faces seemed somehow more 'scientific'. Furthermore, photographs taken over a period of time made visible any changes that may otherwise have passed unnoticed. The growing importance of the photograph in identifying degeneracy was illustrated by Francis Galton, Darwin’s cousin and fellow evolutionist. He invented a composite photography machine which was supposed to record the inherent physiognomic features of criminality and race.' As noted previously, the insane were by this time thoroughly implicated with the criminal. By 1905, in accordance with this tradition, provision was made so that a photograph on admission and another on discharge could be included with the notes on patients committed to Kew. From this time, specific comments about the appearance of the patient were more commonly recorded.

*Dictionary*, p.338.] This is the procedure popularly known as the bumps on the skull technique.

Physiognomy, however, with which I am primarily concerned for the purpose of this discussion was described in the same dictionary as the 'science treating of the methods of determining character by a study of the face or the countenance. [Stedman, Medical Dictionary, p.1034.]


See also S. Gilman, *Seeing The Insane*, A Wiley- Interscience Publication; John Wiley and Sons in association with Brunner/Mazel Publishers, New York, 1982 for a history of Physiognomy and Phrenology from the Middle Ages to the Nineteenth Century, as explored through Art and Medical Theory.

Pick, *Faces of Degeneration*, p.165. The fascination of Darwin himself with photographic representations is evident in his accompanying volume to *The Descent of Man, The Expression of the Emotions in Man and Animals*, in which photographic images are extensively used.

Acknowled for example, proposes that 'Morel and Moreau believed that the same hereditary predisposition was present in criminals and the insane, and in both it was, a matter of degeneration'. [Acknowled, *Short History*, p.50].

The *JMS*, 1891 claims that 'when cross-questioning criminals, one often feels that not only are their minds weak and wavering, but that they border close on insanity. The same feeling arises after an examination of confirmed paupers'. (A. MacDonald, 'Ethics as applied to Criminology', *JMS*, vol.xxxviii, no.156 (January 1891), p.10.
In keeping with the general recording of patients' symptoms and progress, however, the collection of photographs was somewhat haphazard. The intention was to include at least two photographs of each patient. One was to be taken on admission, and a second upon discharge. A few patients had two or more photographs included with their notes. Many more had only the one. Others had none at all, sometimes with an explanation such as 'too restless for photograph', or similar notation. In other cases, there was neither photograph nor explanation. Nonetheless, the very fact that provision had been made for inclusion of these images indicated the continuing concern with scrutinising the appearance of the inmate.

Physiognomy, like its associate Phrenology, purported to be an exact science, articulated within a language that relied on measurements and graphic representations to proclaim its legitimacy. The *Dictionary of Terms used in Medicine and Collateral Sciences* describes an imaginary geometric arc, 'commencing at the greater angle of the eye, and lost a little below the projection formed by the cheek-bone'. This area, identified as the 'oculo-zygomatic trait', was meant to be 'the index of the disorders of the cerebro-nervous system'.¹⁵ In 1892, John Turner, the senior assistant medical officer at Essex Lunatic Asylum, published an article in the *Journal of Mental Science*. Accompanying the article were diagrammatic representations of this dictionary definition of Physiognomy, accompanied by photographs of individuals who supposedly exhibited facial symptoms which indicated mental disorders. The lengthy article emphasised a lack of balance, or what it described as the:

asymmetrical conditions met with in the faces of insanity [and] a dissolution of expression. [There is] inequality in the size of the pupils ... lateral deviation of the tongue, and the muscles of expression themselves ... the facial muscles ... lose their

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